University of Alberta

SEXUAL ABUSE DETECTION, SEQUELAE, AND THERAPY ACCOMMODATIONS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

by

Sheila Mansell

A paper format dissertation submitted to the faculty of graduate studies and research in partial fulfillment of the requirements for the degree of doctorate of philosophy in counselling in psychology.

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Abstract

This dissertation includes three papers about the sexual abuse of people with developmental disabilities that are based on the results of research conducted with the Abuse and Disability Project at the J. P. Das Developmental Disabilities Centre at the University of Alberta. The dissertation follows a paper format that includes a brief introduction, three separate but related papers (i.e., one literature review and two studies), and a concluding chapter. The introduction provides a brief overview of the scope of the research covered in the dissertation. Definitions, the research questions, methodologies, ethical issues, and potential limitations and benefits for the two studies are presented. In the first paper, the literature on the detection of sexual abuse of students with developmental disabilities and the implications for school personnel is reviewed and discussed. In the second paper, a data analysis consisting of client files obtained through the Victoria Child Sexual Abuse Society (VCSAS) of Victoria, British Columbia, Canada that compares clinical findings in children with and without developmental disabilities who were referred for treatment at VCSAS is presented. In the third paper, selected results of an international survey of mental health and other professionals who work with people with developmental disabilities who have been sexually abused are presented. The survey's results provide a description of the therapeutic practices, accommodations, and treatment components these professionals use and the difficulties they encounter. In the concluding chapter the implications for research and professional training are discussed.

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INTRODUCTION

Identification of the problem

Heightened risk for sexual abuse

The findings of numerous studies indicate that both adults and children with developmental disabilities have a heightened risk for various forms of abuse and maltreatment (Ammerman, Van Hasselt, Hersen, McGonigle, & Lubetsky, 1989; Crosse, Kaye, & Ratnofsky, 1993; Garbarino, Brookhouser, & Authier, 1987; Sobsey, Wells, Lucardie, & Mansell, 1995; Stimpson & Best, 1991; Sullivan & Knutson, 1994; Turk & Brown, 1992). One American prevalence study indicates that compared to children without disabilities, children with disabilities had a relative risk that was 2.77 times higher for emotional neglect, 2.2 times higher for educational neglect, 2.09 times greater for physical abuse, 1.6 times higher for physical neglect, and 1.21 times higher for emotional abuse, in addition to a relative risk that was 1.75 times higher for sexual abuse, than for children without disabilities (Crosse et al., 1993). In the study, 15.2% of all children who were sexually abused had disabilities. Sullivan and Knutson (1994) reported mental retardation in 6.2% of their sample of 2845 abused children, but only in 1.3% of their control group of 880 nonabused children. Abused children were 4.8 times as likely to be mentally retarded. Of all the disability categories in their sample, only "behavior disorders" exceeded mental retardation in association with sexual abuse.

Carmody (1990) reports on the prevalence of intellectual disabilities among adults referred to Sexual Assault Services in New South Wales. Of the 855 adults who were referred, 55 had intellectual disabilities, which is about twice the estimate that would be expected in a random sample. Carmody also found that 12 of 14 adults entering a sex education program in New South Wales reported previous sexual abuse or sexual assault.

Atypical presentations of psychological disturbances

In addition to this heightened sexual abuse risk, the growing dual diagnosis (i.e., the co-occurrence of mental disorders and mental retardation) research indicates that people with developmental disabilities are more likely to suffer psychological disturbances or mental disorders than the general population (Borthwick-Duffy, 1994). It is also notable that mental retardation may cause psychological disturbances to present in atypical ways. Sovner and Hurley (1986) note four pathoplastic factors including *intellectual distortion, cognitive disintegration, psychosocial masking*, and *baseline exaggeration*, that can distort the presentation of mental disorders and significantly complicate diagnosis.

The effects of sexual abuse

Historically professionals have misunderstood the mental health needs of this vulnerable group, and consequently there have been inadequate mental health services. For example, many problematic behaviors have not been recognized as indicators of internal psychological difficulties but have been misattributed to a person's developmental disability, and therefore regarded and treated only as behavior problems. Diagnostic overshadowing is a form of clinical bias that illustrates this misattribution tendency. In diagnostic overshadowing, professionals provide a diagnosis of lesser severity or are less likely to diagnose psychopathology when people are identified as having mental retardation than when people demonstrated similar symptoms but do not have a diagnosis of mental retardation (Levitan & Reiss, 1983; Reiss, 1994). Clinical biases also have been noted in sexual abuse. Burke and Bedard (1994; 1995) suggest that the literature on self-injurious behavior in people with disabilities does not present sexual abuse as a possible antecedent even though the presence of self-destructive behaviors (e.g., self-mutilation) has, for some time, been associated with a history of sexual trauma.

Although there is extensive literature documenting both short and long term sexual abuse effects in the general population (Adams-Tucker, 1982; Briere & Runtz, 1988; Browne & Finkelhor, 1986; Finkelhor & Browne, 1985; Kendall-Tackett, Williams, & Finkelhor, 1993; Lusk & Waterman, 1986) very little is known about these effects in people with developmental disabilities. What is known tends to be drawn from a limited number of therapy case studies or phenomenological studies (Burke & Gilmour, 1993; Cruz, Price-Williams, & Andron, 1988; Hyman, 1993; Martorana, 1985; Perlman &

Sinclair, 1992; Ryan, 1992; Sinason, 1992; Sullivan, Scanlan, Brookhouser, Schulte, & Knutson, 1992; Varley, 1984; Westcott, 1993). It would appear that, although some authors support the hypothesis that sexual abuse issues are similar to those in the traditional child sexual abuse literature, others support the hypothesis that developmental disability related and child sexual abuse issues would interact and produce more complicated effects. However, much of this literature is speculative and there has not yet been sufficient study to indicate in what ways, if any, the presence of a developmental disability may produce atypical sexual abuse effects such as those noted in the dual diagnosis literature (e.g., anxiety, depression, etc.).

Therapy accommodations

In addition to the heightened risk for sexual abuse, mental health problems, and inadequate knowledge of the presentations of sexual abuse, many people with developmental disabilities and their advocates report that therapy services to treat the effects of sexual abuse are often inaccessible, unavailable, or inappropriately adapted (Mansell, Sobsey, & Calder, 1992). Although the response of mental health professionals to the sexual abuse of this vulnerable group is fairly recent, increasing numbers of practitioners have been reporting their adaptations of conventional sexual abuse therapies for children (Perlman & Sinclair, 1992; Sinason, 1992; Sullivan et al., 1992) and adults with developmental disabilities (Cruz, et al., 1988; Ryan, 1992; Sinason, 1992).

Although there has been growing interest in this area, professionals who provide these therapy services continue to constitute a very small minority. Most authors describe what they provide as conventional sexual abuse therapy that is adapted for the client. A persistent problem in most sexual abuse therapy research reports, however, is the lack of standardized sexual abuse treatments. Most reports present general discussions of the treatment issues people with developmental disabilities experience, the therapy provided, and include case examples for illustrative purposes. Unfortunately, most reports are vague and do not inform readers about the use of specific therapy techniques that may be needed (e.g., the use of psychoeducational components dealing with sexuality and social skills, sexual abuse, self-protection, affective vocabulary, and behaviorally oriented approaches), the factors that influence therapists' use of particular accommodations with clients, or describe the distinctive difficulties that they encounter in providing these services.

Notably, some authors writing about generic therapy services with this group have provided some focus on these issues. For example, the reviews of therapy adaptations from Hurley (1989), Hurley, Pfadt, Tomasulo, and Gardner (1996), Strohmer and Thompson Prout (1994), and Reiss (1994), are quite informative. The first provides specific guidelines that consider the problems therapists encounter (e.g., working with the client's system, addressing disability as an issue, etc.) and the latter two emphasize what factors influence the use of specific accommodations (e.g., the use of assessment information about a client's developmental, cognitive, and communicative abilities [receptive and expressive] and the therapist's accommodations). These reviews do not, however, examine the treatment of sexual abuse issues.

Unfortunately, the literature on sexual abuse therapy and developmental disabilities lacks descriptive power to inform other professionals about specific problems, therapy approaches, accommodations, or treatment components. The heightened risk for sexual abuse and mental health problems, and the reduced likelihood of receiving appropriately adapted therapy services suggest at least a few research avenues for examination. Therefore, research in this area should both draw from and extend the knowledge base of this largely case-study-based literature through the use of additional methods and research literatures.

This dissertation follows a paper thesis format that includes three separate but related papers. In the first of these papers, I present a review of the literature that covers the effects of sexual abuse in children with developmental disabilities, with an emphasis placed on the detection of sexual abuse and its potential implications for school personnel. In the remaining two papers, I compare the reported effects of sexual abuse on children with and without developmental disabilities, and describe the results of an international survey of professionals who provide therapy services to people with developmental disabilities who have been sexually abused. Before entering a discussion of these three papers, however, some definitions will be presented. The research questions and the objectives, the ethical issues, and the potential limitations and benefits of these studies, conclude the introduction. The research methods for the two studies in the dissertation differ and will be discussed separately in each paper.

Definitions

Developmental disability and mental retardation

The terms "mental retardation" and "developmental disabilities" are often used interchangeably in the disability and mental health services fields. There are some differences between these definitions. But it is important to remember that the definition, most notably for mental retardation, has not only changed considerably over time but it also varies according to whether the definition's sources come from the disability or the mental health services fields (e.g., the American Association of Mental Retardation, American Psychiatric Association, etc.).

As used in this dissertation, the term developmental disabilities refers to significant long-term impairment of functioning in areas such as intelligence, motor abilities, and personal-social interaction, that occurs before 22 years of age, and is frequently attributable to mental retardation, autism, cerebral palsy, epilepsy, and other conditions. The definition of mental retardation adopted by the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (American Psychiatric Association, 1994) includes the criteria for subaverage intellectual functioning, concurrent impairment in adaptive functioning, and onset prior to age 18 years. This definition also includes the descriptors indicating level of severity (e.g., Mild, Moderate, Severe, and Profound). Mental Retardation, as defined by the American Association of Mental Retardation (Luckasson, Coulter, Polloway, Reiss, Schalock, Snell, Spitalnik, & Stark, 1992), refers to substantial limitation in present functioning. It is characterized by significantly subaverage intellectual functioning (IQ < average, -2 standard deviations), existing concurrently with related limitations in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, and onset before 18 years of age. This most recent AAMR definition is more expansive than previous definitions and no longer includes the descriptors indicating level of severity that were used in previous definitions (e.g., Mild, Moderate, Severe, and Profound) (Grossman, 1983). This most recent definition, however, refers to assessing an individual's strengths and weaknesses and the levels of assistance and community support that are required by the individual (Luckasson et al., 1992). Although the most recent AAMR definition no longer uses the descriptors indicating level of severity, these terms are still widely used in a variety of mental health and disability service settings.

Child sexual abuse

The definition for child sexual abuse offered by Browne and Finkelhor (1986) refers to two types of interactions that include forced or coerced sexual behavior imposed on a child and sexual activity between a child and a much older person, whether or not there is obvious coercion. Child sexual abuse includes a range of acts such as incest, sexual assault, fondling of genital areas, exposure to indecent acts, sexual rituals, or involvement in pornography. Sobsey (1994) defines child sexual abuse as any sexual interaction between an adult and a child aged twelve years or younger or any sexual interaction between adolescents, ages of thirteen to seventeen, in which there is a clear indication of harm, coercion, or exploitation of a relationship of authority or trust.

Treatment or Therapy

Treatment or therapy refers to counselling, education, support, and a variety of other interventions professionals use to help their clients. It may also include providing considerable consultation, education, and support to other professionals and caregivers associated with the client.

Accommodations or adaptations

People with developmental disabilities encompass an extremely heterogeneous group of individuals who have a wide range in abilities in various areas. Accommodations or adaptations refer to any changes, in terms of providing therapy, that a therapist may make to ensure therapy appropriateness for the client's developmental level, communication, comprehension, and language abilities (Hurley, 1989).

Research questions and objectives

The literature review on detecting sexual abuse effects in children with developmental disabilities, and its implications for school personnel, illustrates some of the limitations in our current knowledge. These limitations raise at least a few research questions. Two central research questions are examined by the two studies that are presented in this dissertation.

Firstly, are the sexual abuse sequelae different in children with and without developmental disabilities? Secondly, what are the therapy approaches, accommodations, and components used by professionals, and what problems do they encounter when providing therapy to people with developmental disabilities who have been sexually abused?

The two studies have two central objectives that include: 1) conducting a data analysis of an existing database to describe and to compare the patterns of sexual abuse sequelae in a clinical sample of children who do and do not have developmental disabilities; and 2) conducting a survey with a sample of professionals who provide therapy to people with developmental disabilities who have been sexually abused, to describe any specialized communication training they have, the clients they typically serve, the therapy approaches, accommodation strategies, and components they use, and the problems they encounter providing this service. The research methods for the two studies in the dissertation differ and will be discussed separately in each paper.

Ethics

The sexual abuse sequelae study used the Sexual Abuse Information Record (SAIR) (See Appendices A and B for the complete SAIR) and consent was previously obtained from all the participants by the Victoria Child Sexual Abuse Society (VCSAS) (See Appendix C for the VCSAS application for service form). The study received approval from the ethics committee of the University of Alberta. Permission to use the data generated by the VCSAS was granted to Dr. D. Sobsey, the principal investigator of the Abuse and Disability Project at the J. P. Das Developmental Disabilities Centre at the University of Alberta.

For the study of therapy accommodations, a detailed proposal was presented and approved by the ethics committee at the University of Alberta. To avoid or minimize risk to participants, several protections were built into this study. All potential participants were sent a cover letter describing the study to provide information about what their participation might entail (See Appendix D for the cover letter for the therapist's accommodation survey). This letter indicates that participation is voluntary and that all information will be kept confidential. Participants were specifically asked to preserve the confidentiality of those persons they serve, using no names or other identifying information that might harm their clients. Completion of the questionnaires indicates participants' consent to participate and follow the guidelines set forth in the study (See Appendix E for the Therapist's Accommodation Survey).

Limitations of the studies

The data base obtained from the VCSAS is comprised of subjects who were receiving treatment. This nonrandom sample for two years of consecutive admissions (n=452) receiving treatment clearly may not necessarily be representative of sexually abused individuals who do not receive treatment or those receiving treatment at other centres. This lack of representativeness, however, may be offset somewhat by the fact that the VCSAS treatment program was funded by the government of British Columbia, making services more accessible to individuals who ordinarily may not have been able to afford services. Nevertheless, the fact that the subjects were entering a treatment program may have considerable implications for the sexual abuse sequelae under consideration in this study. In addition, the sample of sexual abuse victims was drawn from a specific region in North America which may not be representative of other areas. Thus, there may be some limitations on the generalizability of the results.

The survey of professionals presents concerns about the generalizability of the study's results. Potential participants were targeted either because they were known by reputation to possess expertise in this area (i.e., they had published articles or presented at conferences on this subject) or they had professional affiliations with the previously mentioned organizations. However, it is very difficult to determine either the response rate or the actual representativeness of the respondents in the sample engaged in this practice. Over 300 surveys were sent out and 105 were returned within a three month period. Some addressees, however, responded that they did not feel that they could respond to the survey but had distributed it to other professionals. Also, as a self-selecting, non-random sample, the responses of these respondents may not be representative of those professionals involved in providing this service who either chose not to respond to the survey or were not targeted as potential participants.

Potential benefits

The data analysis comparing the sexual abuse sequelae of children with and without developmental disabilities may provide much needed comparative information. This data may stimulate additional research on sexual abuse sequelae and developmental disabilities and may have a number of implications for the refinement of treatment components, professional training, and sexual abuse detection.

Using a survey method to study the accommodations therapists use when providing therapy services has several potential benefits. The use of this method is cost effective and time efficient. In addition, the survey may provide (a) more detailed, descriptive information about the conditions that dictate the use of specific therapy techniques and accommodations with particular clients, (b) greater clarity about the distinctive problems encountered by these professionals, and (c) an impetus for more research that may have implications for development of professional training programs, treatment protocols, and greater cooperation between disability and mental health disciplines. Increased development in all of these areas may help alleviate the inadequacy of sexual abuse treatment services and encourage the provision of more integrated mental health services for people with developmental disabilities.

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CHAPTER 1.

Detecting sexual abuse of students with developmental disabilities: Considerations and implications for school personnel

ABSTRACT

Children with developmental disabilities are more likely to be sexually abused than other children, but little is known about the effects of sexual abuse on children with developmental disabilities. Some researchers suggest that the effects are similar to those found in the children without disabilities, but that these effects may be complicated by disability-related issues. The documented effects and indicators noted in children, adolescents, and adults with developmental disabilities are discussed. Primary emphasis is placed on sexual abuse detection skills for school personnel who are working with students who have developmental disabilities. Implications and considerations for reporting, protocol, and intervention issues for school personnel are discussed.

Detecting sexual abuse of students with developmental disabilities: Considerations and implications for school personnel

Children with developmental disabilities have a heightened risk for sexual abuse compared to children who do not have disabilities. Authors of a recent prevalence study based on representative samples in the United States, indicate that children with disabilities have a risk for sexual abuse that is 1.8 times that of their non-disabled peers (Crosse, Kaye, & Ratnofsky, 1993). Similarly, Canadian researchers have suggested that children with disabilities are at least 1.5 times as likely to be sexually abused as other children of the same age and gender (Sobsey & Varnhagen, 1989). Sullivan and Knutson (1994) reported mental retardation in 6.2% of their sample of 2845 abused children, but only in 1.3% of their control group of 880 nonabused children. Thus, abused children were 4.8 times as likely to have mental retardation. Of all the different types of disabilities in their sample, only "behavior disorders" exceeded mental retardation in the strength of association with sexual abuse. Sobsey & Mansell (1997) found that children with developmental disabilities were 3.0 times as likely as children without disabilities to be sexually abused. Verdugo, Bermejo, and Fuertes (1995) found that Spanish children with developmental disabilities were 7.6 times as likely to be abused as other children. Among children with developmental disabilities 11.5% were abused compared to only 1.5% of the control group composed of children without disabilities. Children with multiple disabilities appear to experience even greater risk (Sullivan & Knutson, 1994). Ammerman and colleagues report that 39% of multihandicapped children admitted to psychiatric facility had a history of maltreatment (Ammerman, Van Haslett, Hersen, McGonigle, & Lubetsky, 1989).

Mandatory legal requirements in Canada to report suspected incidents of abuse to child protection services, increasing integration of students with developmental disabilities, and the heightened risk for child sexual abuse and variable effects seen in this vulnerable group, have numerous implications for school personnel. These factors underline the importance of school personnel developing sexual abuse detection skills, understanding the implementation of protocol and responding to suspicions of abuse, and using interventions that provide support and help reduce the risk for additional abuse. In this paper I examine the documented literature addressing child sexual abuse effects and the possible indicators in people with developmental disabilities. Also detection skills, issues faced by school personnel when they encounter suspected sexual abuse in students with developmental disabilities, and interventions to reduce risk and provide support are discussed.

The recognition of sexual abuse

The acknowledgment of and professional response to the mental health needs and the sexual abuse of people with developmental disabilities is fairly recent. Historically, the mental health needs of this vulnerable group have been neglected and misunderstood by professionals and, as a result, there has been significant under-service in mental health services. Some attitudes contributing to this situation concern the misconceptions that people with developmental disabilities possessed no inner psychological life and, therefore, were devoid of emotional difficulties and unable to participate in or benefit from therapy. Many behaviors have been misattributed to developmental disability, labeled as behavior problems, and not regarded as indicators of psychological distress or psychiatric difficulties.

Diagnostic overshadowing, is a form of clinical bias, in which professionals are less likely to diagnose psychopathology or provide a diagnosis of lesser severity when people are identified as having mental retardation, than when people demonstrated similar symptoms but did not have a diagnosis of mental retardation (Reiss, 1994). This bias has meant that the possibility of sexual abuse and its associated effects often may have been overlooked. For example, the presence of self-destructive behaviors (e.g., self-mutilation) has long been associated with a history of sexual victimization or trauma. But as Burke and Bedard (1994; 1995) note the literature on self-injurious behaviors does not make reference to sexual abuse as a possible antecedent. Other researchers suggest suicide and suicidal behavior are often overlooked in people with developmental disabilities (Kaminer, Feinstein, & Barret, 1987) as there may be a tendency to see this behavior as self injurious but not suicidal. It is clear that this bias may be operating across many disciplines (Levitan & Reiss, 1983) and school personnel need to be aware of this potential bias when working with their students with developmental disabilities.

Although mental health issues have been misunderstood, considerable research indicates that people with developmental disabilities are more likely to suffer psychological disturbances than the general population (Borthwick-Duffy, 1994). Various psychosocial risk factors that may predispose people to develop psychological or behavioral difficulties include prolonged stigmatization and other negative social conditions (e.g., labeling, rejection and social disruption, restricted opportunities, and victimization, etc.) (Reiss & Benson, 1984). Also, the growing dual-diagnosis research literature (mental retardation and mental disorders) suggests some psychological difficulties have been both over and under diagnosed. Many psychological problems can present in atypical ways and some of the effects of mental retardation can significantly complicate the diagnostic process (Sovner, 1986).

Effects of child sexual abuse

The effects of child sexual abuse are highly variable and do not form a definitive constellation of symptoms. For example, some people may experience seemingly minimal effects whereas others experience severe psychiatric symptoms requiring intensive therapy. There has been considerable research that documents both initial and long term effects of sexual abuse in children without disabilities (Browne & Finkelhor, 1986; Eth & Pynoos, 1985; Lusk & Waterman, 1986; Terr, 1991). For example, a recent meta-analysis of 45 studies on child sexual abuse effects suggests that fears, post-traumatic stress disorder, behavior problems, sexualized behaviors, and poor self-esteem are among the most frequently occurring sequelae of child sexual abuse (Kendall-Tackett, Meyer-Williams, & Finkelhor, 1993). However, research describing sexual abuse and assault, as it affects children and adults with developmental disabilities, is relatively scarce (Cruz, et al., 1988; Martorana, 1985; Perlman & Sinclair, 1992; Ryan, 1992; Sinason, 1992; Varley, 1984; Westcott, 1993). This case-study-based literature emphasizes the similarities in the effects noted in nondisabled children and adults, but also incorporates the influence of disability related issues. Findings from the literature on abuse effects and indicators will be discussed.

Similar effects

Some researchers suggest many effects of trauma on individuals with developmental disabilities are similar to (Ryan, 1992) and appear to share the same range of variability found in people without disabilities (Gorman-Smith & Matson, 1992). Cruz, Price-Williams, and Andron (1988) identified issues in a group of women with developmental disabilities, who were referred for treatment because they were described as "acting out" (i.e., being overly friendly with strangers or sexually permissive; having poor discrimination skills regarding safe and unsafe situations; exhibiting depressed, self-abusive, or suicidal behavior when upset; showing hypervigilance and defensive behavior around males). These women received counselling for issues related to personal loss and parental relationships, guilt, intimacy needs, lack of self-esteem, dependency, feelings of social isolation, difficulty handling and expressing anger, concerns and confusion about their sexuality, and feelings that they were "damaged goods" (Cruz, et al., 1988).

Disability-related issues

Many sexual abuse issues appear to be compounded by issues related to developmental disability, such as the experience of social isolation and alienation which can exacerbate loneliness and a sense of stigma; dependency on others particularly family which can heighten anxiety, anger, and fear of retaliation and abandonment; and inadequate knowledge of and comfort with their sexuality (Cruz et al., 1988). Also, negative feelings associated with having a developmental disability may compound poor self-esteem and guilt. Sullivan and colleagues (1992) identified sexual-abuse treatment goals for children with various disabilities that include alleviating guilt, regaining the ability to trust, treating depression, helping children express anger, teaching about sexuality and relationships, self-protection techniques, an affective vocabulary to label feelings, sexual preference, sexual abuse issues, and treating secondary behavioral problems.

Greater behavioral problems and exacerbation of disabilities

Some researchers suggest that the effects of child sexual abuse may include greater behavioral difficulties. In Dunne and Power's (1990) study of sexually abused adults they outlined behavior problems and other indicators that they assert represent attempts to communicate distress where a person has poor verbal expressive skills. They identify short-term effects as generalized anxiety, distress, and fearfulness. They also found long-term effects including greater vulnerability to revictimization, increased restrictiveness placed on their freedoms, long-term anxiety and depression, and inappropriate sexual behavior.

Other researchers suggest that trauma may exacerbate physical and cognitive disabilities. Bowers-Andrews and Veronen (1993) note that trauma can magnify speech problems and that a person with a developmental disability may have greater confusion and difficulty in understanding his or her sexual abuse experience. Sinason (1986) suggests that sexual abuse trauma often worsens an existing disability by creating a secondary disability that protects the person against the trauma. Sinason suggests that some apparent impairment of communication and thinking attributed to mental retardation often partially results and sometimes entirely results from traumatic effects of abuse.

Some researchers assert that effects are more devastating because of greater coping difficulties and vulnerability; and that the responses of people with developmental disabilities are qualitatively different (Gorman-Smith & Matson, 1992). Mansell and Sobsey (in press) suggest limited coping resources and developmental-disability-related issues that may include: low self-esteem, internalized self-hatred, feelings of inadequacy and isolation, repeated experiences of failure, poor communication skills, limited sexuality knowledge, and prolonged dependency may all potentially exacerbate the effects (in press). In addition, the presence of multiple disabilities may have profound influences that affect a person's total behavior (Sullivan & Scanlon, 1987).

Both Varley (1984) and Martorana (1985) present case studies of adolescents with mild developmental disabilities who developed Schizophreniform psychoses following sexual assault. Varley (1984) notes that people with developmental disabilities are more vulnerable to psychiatric disturbances and that their likely lesser ability to deal with their emerging sexuality or to physically defend themselves may produce qualitatively different responses to sexual assault. Westcott's qualitative study of adults (1993) indicates that the effects reported across all groups who were interviewed (people with cognitive disabilities, physical disabilities, or no disabilities) appeared to be consistent with the child sexual abuse effects literature. Differences for adults with developmental disabilities include greater long-term fear, specifically extreme fear about repercussions and personal vulnerability. Much of this literature is speculative and more rigorous study is required to evaluate the exact nature and extent of the relationship between the effects of child sexual abuse and developmental disability. Nevertheless, this literature suggests some considerations for detecting child sexual abuse.

Behavioral, psychological, and physical indicators

Mansell and Sobsey (in press) outlined various behavioral, psychological, and physical indicators that may be suggestive of child sexual abuse (see Table 1). These may include, but are not limited to, the following: inappropriate sexual behavior (e.g., sexual attention to pets or animals, simulated sexual behavior with siblings or friends, compulsive sexual behavior, inappropriate sex play for age or developmental level, graphic depiction in artwork that is suggestive of either experience or exposure to sexual activity or violence), onset of sexual aggression (e.g., sex talk, touching the body parts of others, etc.), and the onset of personal sexual behavior (e.g., masturbation, putting dangerous objects into the genitals with no indication of pain, self-exposure, etc.).

Table 1 Behavioral and psychological indicators of child sexual abuse

Behavioral Changes	Sexual Behaviors	Anxiety Related Behaviors	Depression Related Behaviors
Sudden changes in feelings about particular places, events or person(s) (e.g., a person becomes angry or fearful when receiving intimate care), changes in behavior and performance (e.g., at school or work), antisocial, aggressive, or regressive behaviors, coping problems, and decline in independent living skills.	Inappropriate sexual behavior for age or developmental level, onset of sexual aggression (e.g., sex talk, touching others, etc.), onset of personal sexual behavior.	Psychosomatic symptoms, post-traumatic stress disorder (e.g., avoidance behaviors, hypervigilance, re-experiencing trauma through nightmares, feelings, thoughts, sensations, etc.), obsessive-compulsive behaviors, fears and phobias.	Changes in eating (i.e., weight) or sleeping habits (increases or decreases), social withdrawal, emotional lability (e.g., mood swings, crying spells, anger outbursts, etc.), self-destructive or impulsive behaviors, compliance, concentration problems, and dissociation.

Indicators may also include sudden changes in feelings, behaviors, academic performance, and so forth. These may include sudden changes in feelings about a particular person(s) (e.g., fears, fear of contact, or anger). There may be behavioral changes including aggression, compliance, depression, or social withdrawal. For example, there may be changes in eating or sleeping habits that might indicate the presence of depressive symptoms. These may include sleep disturbances (e.g., nightmares, sleep walking, insomnia, hypersomnia, etc.) and either increases or decreases in appetite and weight. There may be changes that suggest the presence of anxiety related and post-traumatic stress symptoms. For example, a person may report nightmares, or the onset of psychosomatic symptoms (i.e., recurring physical ailments with no apparent organic base such as frequent stomach-aches, persistent sore throats, vomiting, etc.). A person may exhibit avoidance behaviors, hypervigilance, and may re-experience a trauma or trauma related triggers through intrusive thoughts and feelings, sensations, or flashbacks, etc.). Other behavioral changes may include heightened distractibility and daydreaming, repetitive or obsessive-compulsive behaviors, and emotional lability. There may be declines or increases in academic performance. Although a decline would seem to be more likely to occur in a child with a developmental disability and therefore more likely to attract the attention of school personnel it is also possible that there could be improvements in academic performance and increased compliance that may indicate a child could be overcompensating. This coping strategy is sometimes used when a child attempts to cope with or conceal the sexual abuse.

There may be greater behavioral disturbances in the classroom and elsewhere. For example, a child may exhibit regression to infantile behavior (e.g., enuresis, encopresis, smearing, or the loss of independent living skills); the onset of self-destructive behaviors (e.g., drug abuse, prostitution or indiscriminate sexual activity, self mutilation, suicide attempts, etc.); obsessive-compulsive, repetitive or impulsive behaviors (e.g., head-banging, self-biting, hair-pulling, etc.); and the onset of antisocial behavior (e.g., stealing, verbal aggression, running away, etc.). A person may exhibit elective mutism or the initiation of sounds (e.g., humming, groaning, etc.) (Mansell & Sobsey, in press) and may exhibit fearful reactions when receiving intimate care (Marchant & Page, 1992).

Physical indicators may include unusually frequent requests to use the bathroom, difficulty voiding, difficulty swallowing or a gagging response, discomfort in sitting or walking, or pain or itching in the genital area or throat. These indicators may suggest the presence of possible injuries or infections to the genitals, urinary tract, or throat. These indicators may also suggest the presence of sexually transmitted diseases (STD) (Mansell & Sobsey, in press). The presence of a STD would clearly warrant further investigation. However, it is important to remember that the mere presence of a sexually transmitted disease is not always diagnostic of sexual abuse.

Any of these signs in combination, however, would likely suggest some cause for concern about the person's psychological well-being for school personnel and other professionals, and further exploration into the cause of these difficulties would be warranted. School personnel are in an excellent position to provide valuable information about a student's functioning and any behavior changes that may have occurred. They are also in a significant position to provide support through various school based interventions because of their ongoing relationships with their students.

Disclosure

When a student is experiencing trauma-related difficulties, these may be exhibited in a wide variety of ways and settings that include the development of potential behavioral and learning difficulties in the classroom and in other settings. School personnel need to be aware that their students with developmental disabilities are at higher risk for being victims of child sexual abuse and that the effects they may present may differ from what the personnel have encountered with children who do not have developmental disabilities.

Some researchers suggest that both adults and children with developmental disabilities, respectively, may be less likely to directly disclose their sexual abuse (Dunne & Power, 1990; Moskal, 1995). Marchant and Page (1992) note that spontaneous verbal, disclosure may be especially rare when a person has communication problems and that the signs of abuse may be subtle (e.g., when a person exhibits changed emotional reactions when receiving intimate care). Although this situation may occur in children who do not have disabilities, some additional influences may be operating for the child with a developmental disability. For example, lack of direct verbal disclosure may be due to a child's fears of retaliation or threats from the offender and fears of punishment from others. Researchers have noted the significance of resulting long-standing fears (Cruz et al., 1988; Westcott, 1993). Children with a developmental disability may have limited communicative abilities or they may lack the language or vocabulary necessary to describe their body parts, sexual acts, or even their feelings (Marchant & Page, 1992). Also they are less likely to have received education in social skills and personal boundaries, relationships, sexuality, self-protection, or assertiveness. Children with developmental disabilities may not recognize their own abuse; particularly if it is in the context of a trusting relationship with an authority figure, the child is isolated, lonely, and rewarded for participation, and the abuse is not physically violent in nature.

Problematic professional practices and responses

Some children with developmental disabilities who have well-developed expressive language will verbally disclose abuse. In some cases, these children are more direct and open in their disclosures than most other children, possibly because they do not know or fully understand all of the implications of their disclosure. Direct verbal disclosure of child sexual abuse would appear to be less likely in students with severe developmental disabilities that substantially limit communication. Therefore, it becomes increasingly important that school personnel reconsider some of their traditional responses to behavioral difficulties and consider the possibility that these may represent students attempts to communicate to others about their psychological distress.

Consider the behaviors noted for "Max", a ten-year-old with Down Syndrome who is presently in a third grade integrated classroom. His assessment, two years ago, indicated that he was functioning in the upper mild range of developmental disability. His most recent assessment, six months ago, indicated that he is functioning within the middle moderate range. His teachers note that many of his social interaction and expressive language skills have deteriorated in the past year. Although teachers intially attributed his declines to some changes in his classroom activities, later other possibilities were considered. Over the next few months, his teachers watched him exhibit a behavior pattern that began with him being distractible, tired in class, and withdrawn from classmates. He became more withdrawn, labile, and volatile. Over time his volatility increasingly took the form of sexually aggressive behaviors that were directed toward female classmates (e.g., he was attempting to force girls in his class to touch his genitals). His art teacher noted that his artwork depicted violent content. When she asked him about this he had an explosive, angry outburst, became fearful, and hid under a cupboard in the supplies room. Previous attempts to discuss his behavior problems with his parents were met with resistance and sabotage (i.e., his mother minimized the problems but agreed to meet with teachers but then never attended any meetings). Eventually Max's teachers discussed their concerns with the administrator, who encouraged them to report their suspicions to child protective services. From the investigation it was later determined that Max had been physically and sexually abused by his mother and older sister, and he was subsequently placed in a foster home.

Consider a scenario for a typical teenager. "Caroline", a fourteen year old with a developmental disability, has limited verbal skills and was sexually abused by the schoolbus driver over an undetermined period. Although typically well behaved, Caroline became increasingly agitated, self-injurious (i.e., biting herself), and noncompliant when she had to travel in the school bus. The school personnel responded by placing her on a behavioral program to manage her during daily bus trips and sedating her after which she became very aggressive and then withdrawn. Unfortunately, no consideration was given to exploring the possible reasons for Caroline's behavior. Her abuse was discovered later, after a routine medical checkup revealed that she contracted a STD.

It would seem that the behaviors of these two children were attempts to communicate about their own internal trauma-related or other psychological distress, and the need to escape from or avoid these abusive situations. Attempts to suppress such behaviors (as illustrated in Caroline's case) can result in learned helplessness and add to the trauma of the original abuse. In learned helplessness, a person becomes extremely passive after learning through some experience, that he or she is powerless to control what happens to her or him. It is associated with depression, but the resulting sense of powerlessness, resignation, and poor self-efficacy often leave victims vulnerable to re-abuse because they have learned that they are powerless to stop or even act to prevent it.

Many traditional rehabilitation and special education practices actually have contributed to the heightened abuse vulnerability. The use of practices within schools that contribute to increasing vulnerability to sexual abuse and overlook the psychological needs of people with developmental disabilities need to re-evaluated.

Several practices set people up for victimization (Sobsey & Mansell, 1992). Educational practices contributing to vulnerability include too much focus on teaching compliance (which promotes and rewards passive, obedient, and unassertive behavior), indiscriminate generalization skills training (which fails to teach vital discrimination skills about appropriate relationships, boundaries, and touch), and some sexuality education programs (which may teach mechanics of sexual behavior but fail to address the social and psychological contexts in which sexual behavior occurs). Another problematic practice includes the extensive use of physical prompts and manual guidance. The use of these practices can erode a person's sense of interpersonal boundaries and personal space. People may become uncertain about their physical boundaries and unable to respond appropriately to the gradual, physical intrusions that occur in the "grooming" processes that are used by many abusers to test potential victims. During the grooming process, potential offenders gradually violate boundaries of their potential victims and look for acquiescence as a sign that the individual will be easily victimized (1992).

When people with developmental disabilities exhibit behavior that is viewed as aggressive, self-destructive, or disruptive by their school personnel or other caregivers, the traditional response has been to suppress it through punishment. If the possibility of child sexual abuse is considered, it is critical that school personnel understand the potential functions many behaviors can serve for their students with developmental disabilities.

It is important to consider that there can be considerable overlap and variation in the effects that are seen in child sexual abuse, psychological abuse, physical abuse, and neglect. The presence of some indicators may reflect causes that are attributable to sources other than sexual abuse. Also, it is possible that even if a person's difficulties appear to be recent, these can reflect either actual current difficulties or long-standing ones that may have been recently triggered by trauma-related stimuli, such as the delayed symptoms that can be seen in post trauma reactions. School personnel need to honor and respect the gravity of their legal and ethical responsibilities to protect the children in their care, consider the possible purposes that some behaviors may serve, and be willing to explore the possible cause(s) of a student's behavior(s).

Responsibilities and issues

Role clarification

Additional exploration of the causes of a student's behavior can often leave school personnel and other professionals in a difficult position. Many conflicts surrounding this responsibility concern role clarification in relation to an actual investigation of child sexual abuse. Sometimes school personnel and other professionals can feel overwhelmed and confused about the boundaries of their responsibilities in such cases (i.e., what are the limits of their responsibilities around exploration that is done to determine if there is sufficient evidence to support a suspicion of child sexual abuse and actually engaging in the investigative process). Frequently, school personnel and other professionals will have concerns about how far can they go when obtaining additional information, when they may not have a direct disclosure from a child. Inadequate clarity about these boundaries has resulted in numerous child abuse cases being thrown out of court because concerns were raised about the use of leading questions. Often school personnel have concerns about what kinds of questions they can ask a student that they suspect has been sexually abused, how these questions need to be worded in order to avoid the problems associated with using leading questions, and at what point they should be satisfied that they have enough information to report to child protective services.

School personnel and other professionals, however, will do well to consider the wording of most of the legal requirements to report suspected child abuse. It is not the responsibility of school personnel to determine the veracity of a child's claims, to disprove or substantiate the abuse, or to determine the guilt or innocence of, or confront an accused individual, but it is a responsibility to be alert to the possible warning signs and report this suspicion to child protection services (Quast-Wheatley, 1988). It is crucial that school personnel and other professionals be able to listen, report, and accurately record their knowledge about the situation.

Research suggests that children with developmental disabilities are particularly dependent upon school personnel to report their abuse (Sobsey & Mansell, 1997). More than one-third (36.5%) of all confirmed cases of abuse of children with developmental disabilities are reported by school staff, compared to only about one-fifth (21.8%) of cases involving children without disabilities. Reports from family members occur much less frequently for children with developmental disabilities.

Reporting a suspected incident of child sexual abuse can be personally overwhelming and, sometimes, people may experience vicarious or secondary traumatization. But this experience may be especially difficult if the reporter has any personal experience of trauma. Engaging in this process may trigger a number of post-traumatic reactions that can significantly interfere with a person's emotional functioning and ability to report clearly. In circumstances where there may be concern about a person's ability to carry out these responsibilities, it may be advisable to consult with a trusted colleague about the suspicions, and develop some alternative strategies that ensure that the child obtains what he or she needs. If a person's involvement becomes too overwhelming it is recommended that he or she obtain support either through counselling or therapy and to consider if there are other school personnel who might be of assistance during this process. It is preferable for school personnel to report a suspected case of child abuse that can then be investigated by child protection services and possibly the criminal justice system. Overinvolvement in the investigative process introduces numerous risks and potential consequences that may increase the likelihood that a child, who may be at risk for child sexual abuse, remains unprotected, and that justice is not served.

Apprehensiveness and reporting

In addition, there may be several other complex issues associated with making a report to child protective services. Although over-involvement has been mentioned, the reporting behavior of school personnel can also reflect significant apprehension that occurs for varying reasons. Some aspects of this apprehension to report are evident in the frequently asked questions concerning the reporting process itself, such as, "How do I make a report about suspected child sexual abuse?" and "Who should or shouldn't I be talking to about my suspicions?" which can often be addressed through appropriate consultation with protocols and procedures. Often there is reluctance to report child sexual abuse especially if the suspicions are based on anything that is short of a direct verbal disclosure or physical evidence (e.g., a male student does not say to a teacher specifically what happened to him, with whom, and on what occasions but has been exhibiting aggressive, sexualized behavior with his classmates, has mood swings, appears tired, and has declining school performance, etc.). Because school personnel both recognize and appreciate the personal consequences that can be attached to reports and investigations, they may hesitate when they are unsure if they have enough evidence to substantiate their suspicion. Hesitation can also be present because both recognizing the signs of abuse and the process of reporting can stir up painful feelings for someone with a personal trauma history. Engaging in this process can be painful for school personnel who do not have such a history, and can affect the whole system of the school. Therefore it is important for administration to acknowledge, and make it an administrative priority to ensure, that all school personnel who may be effected are encouraged to obtain appropriate support and guidance, under these conditions.

School personnel can also be apprehensive about reporting suspicions of child sexual abuse if they do not feel that their actions are supported by the school administration. This may be particularly true if allegations of child sexual abuse that are made against a member of the school staff or administration. Of the many barriers there are to reporting suspected child sexual abuse in the context of a system this is perhaps the most insidious. Unfortunately, there is no shortage of stories of chronic, severe incidents of sexual abuses involving both numerous perpetrators and victims in systems ranging from religious institutions and sports organizations, to both integrated and residential schools, and institutions that were maintained by systematically orchestrated conspiracies of silence.

These stories testify to the enormous power that abusers' threats of retaliation can have in creating the substantial fears and powerlessness that silence both abuse victims and others working in the system that is supposed to serve children. Whistleblower and some forms of the adult protection legislation have attempted to address some of the systemic, retaliation issues that have served as barriers to reporting abuse. It is important to appreciate, however, that the social coercion involved in being silenced about abuse may not necessarily involve direct threats of retaliation. The dynamics that encourage silence about abuse may be far more subtle in the context of the sometimes longstanding relationships between co-workers. The desire to appear loyal to a particular relationship or various relationships within the system, or avoid other personal consequences such as social isolation, can be powerful deterrents to responding to the moral and legal obligations to report suspicions of abuse. Failure to respond appropriately encourages the longevity of abuse, results in greater long term psychological problems for the victim and others, and refuses to treat the maltreatment of children with developmental disabilities as a criminal offense.

Although it is important for school personnel to be vigilant of possible warning signs, and to explore these to determine if a report should be made, the intent of the report is to have the situation investigated by someone trained to determine if the child in question is at risk and requires protection. Canadian provinces have legally mandated reporting of suspected child abuse and protocols have been developed that indicate who is responsible for what actions and decisions, who reports what information to whom, and within what time frame. School personnel need to be aware of and follow closely the procedures that are part of the protocol used in their province, because failure to do so can result in significant complications and additional risk for a child. While specific requirements and procedures may vary slightly from one Province to another, it is important to understand that teachers are typically required to report anytime there is reason to *suspect* abuse. It is the responsibility of child protection services and law enforcement to determine whether or not those suspicions are confirmed. When there are additional protocol considerations applied in a particular school district, these also need to be carefully observed. School personnel should consult their protocols and the local child protection authorities if they are uncertain about how to proceed in complicated circumstances.

The effects of reporting

Following the submission of a report to child protective services, there may be numerous possible outcomes that effect a child. Outcomes may include: court preparation and a trial, the removal of a child or children from the home or residence, foster or group home placement, and family breakdown. The child may also lose his or her significant social supports and attachment figures, suffering further emotional trauma and turmoil, and the development of additional psychological personal problems (Quast-Wheatley, 1998). In addition, if the accused is a member of a staff or school administration, there may be an inquiry, the child and his or her siblings may be removed from the school, the accused may be suspended, other staff members may be required to testify in court or at an inquiry, and there may be considerable ambivalence, staff polarization and other consequences for the system. Some of the potential system consequences may be addressed through using outside consultation to address staff dynamics issues, or if an individual requires support to process the incident individual therapy may be helpful.

So far a great deal of attention has been devoted to victims but it is important to remember that child sexual abuse results in significant, often long term turmoil and trauma for victims and their families. Although there are many potential consequences perhaps the most important consideration facing school personnel is how the functioning of the child and family will be effected.

Emotional consequences for the victim and family

The sexual abuse of a family member with a developmental disability places several emotional strains on families. It is likely that the family will require support and guidance. Although people with developmental disabilities experience a similar level of risk for intrafamilial sexual abuse to that found in people without developmental disabilities, a significant source of risk comes from extrafamilial sources (Sobsey, 1994). Following extrafamilial sexual abuse parents may have a strong sense of powerlessness about their ability to protect their child. Parents may become worried and anxious about their child's vulnerability and may experience greater distrust of professionals and other caregivers. Distrust may evolve into greater family involvement in caring for the person but less comfort in using disability-related services and respite care, that could reduce the resilience of caregivers and increase the likelihood of burnout. In addition to the numerous parental responsibilities that require vigilance and sensitivity to reduce their child's risk, sometimes, the best efforts at reducing risk for abuse do not provide absolute protection. This can make parents feel powerless and inadequate. Sexual abuse may also reawaken concerns parents may have about their child's sexuality.

Like the victim, families may have a wide range of responses and the nature of these can have significant effects on the victim. Families who provide overreactive or unsupportive reactions to the disclosure can induce greater trauma in the child, placing additional stress on an already emotionally exhausted family system that limits what potential support may have been available in the relationship. Family reactions that include censoring, blaming, disbelieving or denying responses, protection of the perpetrator, and a child's removal from the family can create greater guilt, rejection, and shame in the child (Quast-Wheatley, 1988), and exacerbate the child's psychological losses and trauma. Although the scenario for the child and his or her family is complicated, there are numerous interventions for school personnel that can promote the school system as a potential support system, and provide opportunities to act proactively to help reduce the risk for further abuse.

School-based interventions

Quast-Wheatley (1988) asserts the importance of developing this support system through promoting and creating a school environment of trust, empathy, encouragement, and safety, to help children cope with these very difficult circumstances. Recommended interventions include the development of groups within the school that are available to students who share similar experiences (i.e., to help children reduce their sense of isolation), life skills (i.e., assertiveness, coping with stress, increasing resourcefulness), sexuality education, and parent education (i.e., increasing their knowledge about community resources and the use of support groups) (Quast-Wheatley, 1988). It is important to consider that the child with a developmental disability is unlikely to have received extensive education in sexuality, sexual abuse prevention, assertiveness, self-protection, and self-esteem; and has likely, throughout his or her education and socialization, been taught to obey caregivers indiscriminately. There are numerous educational interventions that can be used in varying degrees by appropriately trained school personnel to help both children and adults. School personnel may need to collaborate and consult with other professionals to provide interventions to ensure that proactive and reactive measures are taken to help children reduce their risk. Advocacy and support from school personnel and other professionals may be needed to help children with developmental disabilities and their families access more appropriately adapted therapy services.

Collaboration and advocating for treatment services

In addition to school-based interventions, other helpful interventions include those that address distinct aspects of students' sexual abuse vulnerability, support, and treatment needs. Most likely the victim and family will require therapy to process the trauma, and advocacy may be needed to access treatment services. Traditionally many mental health professionals have been reluctant to provide therapy to people with developmental disabilities. Although therapy is most often required, frequently it is inaccessible, unavailable, or inappropriately adapted to meet the needs of people with developmental disabilities (Mansell, Sobsey, & Calder, 1992). Over the past few years, as the need for therapy services became evident more practitioners began implementing various treatments for children (Hindle, 1994; Hyman, 1993; Perlman & Sinclair, 1992; Sinason, 1992; Sullivan et al., 1992) and adults (Caprio-Orsini, 1996; Cruz et al., 1988; Ryan, 1992; Sinason, 1992). Despite these changes, treatment for children with developmental disabilities and their families can still be somewhat difficult to obtain.

When school personnel and other professionals are considering possible treatment or therapy resources to recommend they will need to check out the appropriateness of these resources. It is preferable to find someone with background and experience in conducting family therapy, who understands disability and sexual abuse related issues as these pertain to the child with a developmental disability and his or her family. It is critical that the therapist be creative and flexible. His or her willingness to learn from both the family and other professionals, about the specific communication needs of the child with a developmental disability, has considerable potential for ensuring that services are appropriately adapted to meet the child's needs. As family members know a great deal that can be helpful for both the therapist and school personnel, it is crucial that there be a cooperative relationship and a willingness to communicate and consult with disability related services that may also be required. Professional liaison and cooperation has enormous power to bridge the gaps between mental health, education, and disability disciplines.

The therapist will focus on preparing a child for therapy and helping the child and his or her family process the trauma, but therapy can include many interventions to address issues associated with the child's vulnerability to abuse. For example, various psychoeducational components can be used to provide training in sexuality, social skills and relationships, assertiveness, personal rights, sexual abuse risk reduction strategies, and enhancing communication and skills. Providing family education and support can also be critical to help the family heal from the abuse. Behavioral treatment and consultation may also be used to treat any secondary behaviors resulting from the abuse. Some disability-related services and school personnel are already well equipped to deliver some of these components in ways that an individual therapist may not be able to provide. Cooperation among professionals in the provision of the various supports to address vulnerability issues and treatment services is crucial.

Conclusion

It has become increasingly important that school personnel develop both the awareness of and skills to detect sexual abuse indicators in children with developmental disabilities. School personnel need to have clarity about their roles and responsibilities in reporting suspected child sexual abuse, appreciate the potential influences of personal and systemic issues when engaging in this process, and understand the implementation of their protocols for responding to suspicions of abuse. The numerous interventions that can be used to help children and families reduce the risk for additional abuse, and provide support, can be employed cooperatively by school personnel and other professionals. There are considerable needs that can be addressed through the interventions and advocacy-related activities of school personnel and other professionals. Possible outcomes of interventions and advocacy can be positive: The increased access to inclusive social supports, community resources, and mainstream mental health services will benefit the sexually abused child with a developmental disability and his or her family. Furthermore the greater knowledge of child sexual abuse effects and risk reduction strategies, and greater interdisciplinary communication and cooperation will benefit the community in which the child and his or her family live.

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CHAPTER 2.

The Impact of Sexual Abuse in a Clinical Sample of Children with and without Developmental Disabilities

ABSTRACT

Children with developmental disabilities have a heightened risk for sexual abuse compared to their non-disabled peers, but little is known about the effects of sexual abuse on children with developmental disabilities. Research to date has been relatively rare and comprised almost exclusively of clinical case studies. Some researchers suggest that the effects are similar and appear to share the same range of variability found in the people without disabilities. Others suggest that the effects may be complicated by limited coping resources and disability-related issues. This article presents a discussion of the documented effects of sexual abuse on children and adults with developmental disabilities. It also presents the results of a study describing and comparing the clinical findings in a group of 43 children with developmental disabilities to those in a group of 43 children without developmental disabilities, who were both referred for treatment of child sexual abuse.

The Impact of Sexual Abuse in a Clinical Sample of Children with and without Developmental Disabilities

Authors of a recent prevalence study, based on nationally representative samples in the United States, indicate that children with disabilities have a risk for sexual abuse that is 1.8 times that of their non-disabled peers (Crosse, Kaye, & Ratnofsky, 1993). Sullivan and Knutson (1994) reported mental retardation in 6.2% of their sample of 2845 abused children, but only in 1.3% of their control group of 880 nonabused children. Thus, abused children were 4.8 times as likely to be mentally retarded. Of all disabilities present in their sample, only "behavior disorders" exceeded mental retardation in the strength of association with sexual abuse. Mental retardation was the most frequent disability associated with neglect and the third most frequent disability associated with physical abuse.

Despite the heightened risk, an international survey of people with disabilities who have been sexually abused, and their advocates, indicated that therapy and counselling are often inaccessible, unavailable, and inappropriately adapted (Mansell & Sobsey, in press; Mansell, Sobsey, & Calder, 1992; Sobsey, 1994). The professional response to the mental health needs of people with developmental disabilities, who have been sexually abused, is fairly recent. This is due, at least in part, to the influence of long-standing beliefs that people with developmental disabilities could not benefit from traditional, verbally oriented therapies. That perspective has been challenged in recent years by numerous practitioners and researchers who documented their implementations of conventional sexual abuse treatments for both children (Perlman & Sinclair, 1992; Sinason, 1992; Sullivan, Scanlon, Knutson, Brookhouser, & Schulte, 1992) and adults (Burke & Gilmour, 1993; Caprio-Orsini, 1996; Cruz, Price-Williams & Andron, 1988; Hindle, 1994; Hyman, 1993; Mansell & Sobsey, in press; Morris, 1993; Ryan, 1992; Sinason, 1992) with developmental disabilities. The growing professional response to the treatment needs of people with developmental disabilities who have been sexually abused, indicates the importance of research that examines the associated treatment issues for this vulnerable group.

Research describing sexual abuse and sexual assault, as it affects people with developmental disabilities, is relatively scarce because the traditional sexual abuse effects literature almost exclusively examined adults and children without disabilities. At this time, literature concerning sexual abuse effects experienced by children and adults with developmental disabilities is speculative. It is not based on empirical data, but takes the form of anecdotal clinical case studies describing treatment or phenomenological accounts (Cruz, et al., 1988; Martorana, 1985; Perlman & Sinclair, 1992; Ryan, 1992; Sinason, 1992; Varley, 1984; Westcott, 1993). These reports tend to emphasize the similarity of the effects found in the general population. However, many reports also integrate the potential influences of developmental disabilities on those effects.

Sexual abuse treatment issues in people with developmental disabilities

Similar effects.

Some researchers suggest that many effects of sexual abuse on people with developmental disabilities are similar to the effects seen in other people who have been sexually abused (Cruz et al., 1988), and share the same range of variability (Gorman-Smith & Matson, 1992). Ryan (1992) suggests, from her sample of adults with developmental disabilities who experienced traumas including sexual abuse, that many experienced dissociative states, emotional withdrawal, and post-traumatic stress disorder. Cruz et al., (1988) identified treatment issues in a group of women, who were referred because they were described as "acting out" (i.e., being overly friendly with strangers or sexually permissive; demonstrating poor discrimination skills regarding safe and unsafe situations; exhibiting depressed, self-abusive or suicidal behavior when upset.) They note that these women had treatment issues surrounding loss and parental relationships, guilt, intimacy needs, lack of self-esteem, dependency, feelings of social isolation, difficulty handling and expressing anger, confusion about their sexuality, and feelings about being "damaged goods" (Cruz et al., 1988).

The influence of disability related issues. Many sexual abuse issues appear to be compounded by factors related to developmental disability. These include the experience of social isolation and alienation, which can exacerbate loneliness and a sense of stigma; dependency on others, particularly family members, which can heighten anxiety, anger and fear of retaliation and abandonment; and inadequate knowledge of, and comfort with, their sexuality, which can complicate their ability to understand their abuse (Cruz et al., 1988). Strong, negative feelings associated with having a developmental disability may compound poor self-esteem and guilt (Cruz et al., 1988). Sullivan and Scanlon (1990) identified sexual abuse treatment goals for children with various disabilities that include: alleviating guilt; regaining the ability to trust; overcoming depression; expressing anger appropriately; learning about sexuality and interpersonal relationships; developing self-protection techniques; building an affective vocabulary to label feelings, sexual preferences and sexual abuse issues when appropriate; and secondary behavioral problems.

Greater behavioral difficulties and intensified responses. Some researchers believe the effects of child sexual abuse may include greater behavioral difficulties. Dunne and Power (1990), drawing from a sample of 13 sexually abused adults, outlined a range of behavior problems, or indicators, that they believe represent attempts to communicate distress where a person's verbal expressive skills are poor. They identify short-term effects as generalized anxiety, distress, and fearfulness. Long-term effects included greater vulnerability to revictimization, increased restrictiveness placed on their personal freedom, long-term depression and anxiety, and inappropriate sexual behavior (Dunne & Power, 1990). Other researchers suggest that trauma may exacerbate physical and cognitive disabilities. Bowers Andrews and Veronen (1993) note that trauma can magnify speech problems, and that a person with a developmental disability may have greater confusion and difficulty in understanding his or her sexual abuse. Sinason (1986) suggests that sexual abuse trauma may worsen the existing disability by creating a secondary disability that is used as protection against trauma.

Unfortunately, the mental health needs of people with developmental disabilities have often been misunderstood and many behaviors have been misattributed to developmental disability, labeled as behavior problems, and not addressed as possible indicators of psychological distress, or of potentially treatable psychiatric disorders. For example, the presence of self-injurious behavior (e.g., self-mutilation) has long been associated with a history of sexual victimization, or other forms of trauma when it occurs in people without developmental disabilities, however, as Burke and Bedard (1994; 1995) note, the literature on self-injurious behavior does not make reference to sexual abuse as a possible antecedent. Diagnostic overshadowing is a form of clinical bias in which professionals are less likely to diagnose psychopathology, or provide a diagnosis of lesser severity, when people are identified as having mental retardation than when people demonstrate similar symptoms, but do not have a diagnosis of mental retardation (Levitan & Reiss, 1983). This clinical bias means that both the possibility of sexual abuse and its associated effects are likely to be overlooked.

Some researchers assert that the responses of people with developmental disabilities appear to be intensified or qualitatively different (Gorman-Smith & Matson, 1992), and that the effects are more devastating because of coping difficulties and additional vulnerability to abuse (Tharinger, Horton, & Millea, 1990). Both Varley (1984) and Martorana (1985) present case studies of adolescents with mild developmental disabilities who developed Schizophreniform psychoses following sexual assault. Varley (1984) notes that greater vulnerability to psychiatric disturbances and other influences (e.g., less ability to deal with their emerging sexuality, or to physically defend themselves) may produce a qualitatively different response to sexual assault. Westcott's qualitative study (1993) revealed that all three groups who were interviewed (adults with cognitive disabilities, physical disabilities, or no disabilities) reported effects that were consistent with the child sexual abuse effects literature. Notable differences for adults with developmental disabilities include greater long term fears about repercussions and strong perceptions of personal vulnerability (Westcott, 1993).

Vulnerability to emotional distress. Mansell and Sobsey (in press) suggest that developmental-disability-related issues may complicate a person's ability to cope with the effects of abuse. For example, both children and adults with developmental disabilities may have coping difficulties related to: socialization practices that promote prolonged dependency and low self-esteem; limited communication, problem-solving, and relationship skills; limited sexuality knowledge and lack of normative social sexual experiences; and a susceptibility to developing psychological problems. In addition, the presence of multiple disabilities may have broad and complex consequences that affect a person's total behavior (Sullivan & Scanlon, 1987). Psychosocial risk factors such as prolonged stigmatization and other negative social conditions (e.g., labeling, rejection and social disruption, restricted opportunities, victimization, and infantilization) may predispose people to develop psychological difficulties (Reiss & Benson, 1984). Research on children's resiliency-enhancing personal characteristics (i.e., those that provide some inoculation, or protection, against the effects of stress and developing psychological problems) suggests the importance of high self-esteem, a sense of achievement, good problem-solving skills, and high intelligence (Garmezy, 1983; Rutter, 1983). Children with developmental disabilities would be less likely to possess protective factors that could potentially lessen the effects.

As suggested by the preceding review, many authors support the hypothesis that sexual abuse issues for children and adults with and without developmental disabilities are similar. Other authors suggest that a variety of interactions between developmental disability and child sexual abuse produce greater difficulties and even qualitatively different responses. Much of this literature is speculative and based on clinical experience, however, systematic data collection is lacking. For example, none of this literature systematically compares the clinical findings of sexually abused children with and without developmental disabilities to determine the similarities or dissimilarities between these groups. Further research is required to determine if there is a relationship between the effects of child sexual abuse and developmental disability.

The study presented here uses data obtained in the development of a structured sexual abuse reporting record, the Sexual Abuse Information Record (SAIR) to describe the clinical findings in a group of 43 children with developmental disabilities. These findings in children with developmental disabilities are compared with those from a group of children without disabilities who were referred for treatment at the same sexual abuse treatment center. The authors hypothesize that children with developmental disabilities will exhibit similar clinical findings when compared to children without developmental disabilities. In this study the independent variable is developmental disability and the dependent variables are the clinical findings reported on the Sexual Abuse Information Record (SAIR).

Method

The Sexual Abuse Information Record

The SAIR was developed to provide counselors and other professionals, who regularly encounter child sexual abuse in their work, with a structured reporting record of events and findings associated with child sexual abuse (Moskal, 1995). The SAIR has 149 items and is comprised of four parts which cover victim demographics, individual and family history of abuse, offender demographics, and sexual abuse sequelae. This latter part includes seven broad categories of items concerning school/academic/work activities, personal relationships, sexuality, bedtime, hygiene, behavioral/emotional, and medical clinical findings. Only a brief discussion of the development of the SAIR is presented here, as a more detailed discussion exceeds the scope of this article and is available elsewhere (Moskal, 1995).

The SAIR was developed in three phases. The first phase included a literature review that resulted in a rough framework of specific items and generalized item categories (e.g., victim and offender demographics, and sequelae experienced by the individual at the time of counselling, etc.). The second phase involved examining these roughly generated items on a sample of counselling files from children who were referred for treatment of sexual abuse. Ongoing consultation with child sexual abuse professionals and clients led to SAIR item revisions and the refinement of larger constructs into more discrete items. Throughout these two phases there was an ongoing, systematic evaluation by experts in the fields of child sexual abuse, child welfare, and research, to assess the face and content validity of the SAIR's coverage of the child sexual abuse effects domain. As a recording form, the SAIR's face and content validity were judged to be adequate. Nevertheless, additional research will be required to determine its reliability and validity for specific discriminative or predictive functions. As used here, it should be considered simply as a data collection protocol applied to a treatment sample that includes two groups of children referred for treatment of child sexual abuse. In the third phase, the SAIR was applied to a non-random sample of files of consecutively admitted clients following their referral for treatment. The two most recent years of operation at the center were used as the criterion for file selection. The sample of client files ranged from those recorded at the beginning of counselling sessions to those recorded at the termination of therapy.

Procedure

Information in the files consisted of counsellors' anecdotal assessments and reports of ongoing clinical interviews. The researcher did not personally meet with clients, but read the clients' files and recorded information from each file on a corresponding SAIR. Each file and SAIR were reviewed in consultation with each counselor and information was added or adjusted on the SAIR as necessary. Although the SAIR was designed to record a range of data about a person's sexual abuse, the disclosure of information concerning the outcomes of the abuse investigations was more difficult to obtain. Obtaining this information was complicated for numerous reasons such as the time frame used in the study (i.e., abuse investigations may cover long time periods), the low rates of sexual abuse reporting, and the reduced likelihood of obtaining this information from a sample receiving treatment. This information could be obtained for only 58% of the children in this treatment sample. Therefore, it is difficult to determine how many of the children in treatment were victims of substantiated child sexual abuse.

Emphasis in this study is placed on comparison of the clinical findings reported using the SAIR for the two groups. The effects of sexual abuse are highly variable. Some of this variability may be attributed to the influences of various mediating or protective factors (e.g., nature and severity of abuse, personal resiliency, etc.), developmental changes over time; and the combined and overlapping effects of sexual, psychological, and physical abuse (Briere, 1992). The clinical findings noted in this treatment sample are not necessarily produced exclusively by child sexual abuse experiences, but may be due to many possible experiences which may or may not include actual substantiated child sexual abuse. Also, some items may not directly reflect the effects of sexual abuse as much as differences related to the presence of a developmental disability and other associated life circumstances. The description provided here focuses on the comparison of clinical findings found in these two groups of children and adolescents who were referred to receive treatment of child sexual abuse.

Analysis

The analysis of the results provides a description of the frequent clinical findings reported among children and adolescents with developmental disabilities who were referred to receive treatment for child sexual abuse. It is an exploratory study, examining whether the clinical findings occur in similar or dissimilar percentages in the two groups of children and adolescents who do and do not have developmental disabilities. Because the data are categorical, Chi-Square tests of independence were used. Yates' continuity corrections were calculated when cells had less than the minimum expected count required for the Chi Square. Since this study requires multiple comparisons, a conservative probability level ($p < .01$) was chosen to identify significant relationships. In view of the exploratory nature of this study, however, we also identified variables in a broader probability level ($p < .05 > .01$) as findings needing further investigation. For those variables with probability levels between .01 and .05, we cannot conclude that significant differences exist. Nevertheless, it would be premature and potentially misleading to rule out the possibility of such differences.

Sample

The sample was comprised of children and adolescents receiving treatment at a child sexual abuse treatment center on the west coast of Canada. The treatment center provides personal safety skills and treatment for children, adolescents, and adults who allege, or whose guardians allege, child sexual abuse. Most of the children and adolescents receiving treatment at this center were referred by caregivers, various professionals, and advocates. Therefore, this sample may not be representative of people who self-refer for treatment services. Although this center primarily provides treatment to the general public, it has also received provincial funding through a special project intended to ensure treatment accessibility for both aboriginal people and people with disabilities. A large proportion of the children with developmental disabilities (70%) in the sample gained access to treatment through this special funding project. There were no children without disabilities receiving treatment services through this special funding project. Of the children in the sample, aboriginal status was noted for 21% of the children with developmental disabilities and 7% of the children without disabilities.

In the entire sample there were 452 children and adolescents, including 102 of whom were identified as having various disabilities such as: physical disabilities (22%), psychological disabilities (5%), neurological disabilities (13%), intellectual disabilities (IQ below 69) (40%), autism (4%), mobility disabilities (4%), fetal alcohol syndrome/fetal alcohol effects (7%), learning disabilities (3%), attention deficit disorder with hyperactivity (ADHD) (10%), visual (4%) and hearing impairments (8%), and other unspecified disabilities (6%). The percentages provided for the disability categories, however, do not necessarily represent the relative risk for sexual abuse due to the non-random nature of the sample.

From the sample of 102 children and adolescents with disabilities, 43 with global developmental disabilities were selected. For the purpose of this study, we defined global developmental disabilities as a diagnosed disability typically affecting learning and cognitive skills, and most areas of adaptive functioning. We included all people identified as having intellectual disabilities, autism, or fetal alcohol syndrome, but did not include other disorders that typically affect only one, or a few, areas of adaptive functioning. The comparison group of 43 children without developmental disabilities was matched for age and gender from the remaining 350 children who did not have identified disabilities and were receiving treatment at the center. In both groups 33% of the participants were male and 67% were female. Because age matching criteria allowed for a few months difference between individual subjects and matched controls, mean ages for the males and females in the developmental disability group were 5.9 years and 7.2 years respectively. The mean ages for the males and females in the non-disability group were 5.8 years and 7.3 years respectively.

Characteristics of sexual abuse

Before presenting the clinical findings, it is important to describe the specific nature of the children's abuse experiences recorded on the SAIR. Similarly, before making even exploratory comparisons of clinical findings between these two groups, it is important to determine if the nature of the abuse experience was similar. Information describing the abuse experienced by members of both groups is briefly summarized here.

Most (92%) of the children with developmental disabilities in our sample reported experiencing more than one episode of abuse. Similarly, a majority (88%) of the children without disabilities experienced multiple episodes of abuse. Degree of intrusiveness was defined as very intrusive (i.e., completed and attempted vaginal, oral, anal intercourse, cunnilingus, analingus), intrusive (i.e., completed and attempted genital fondling, simulated intercourse, digital penetration), less intrusive (i.e., completed and attempted acts of intentional sexual touching of clothed breasts or genitals), and non-intrusive (i.e., no physical contact-exhibitionism, obscene call). The largest group among both groups of children experienced very intrusive abuse, and the smallest group experienced non-intrusive abuse. Among children with developmental disabilities, 46% experienced intrafamilial abuse, 36% experienced extrafamilial abuse, and 18% experienced both. Among children without disabilities, 38% experienced intrafamilial abuse, 52% experienced extrafamilial abuse, and 10% experienced both. Frequencies for extrafamilial abuse for children without developmental disabilities (52%) exceeded those for children with developmental disabilities (36%), but the frequencies of both forms of child sexual abuse were greater for children with developmental disabilities (18% compared to 10%). Concurrent abuse (i.e., physical, emotional, or neglect) was reported for one third of the children without disabilities (33%) and close to one fifth of the children with developmental disabilities (19%).

The duration of sexual abuse ranged from less than a month to 192 months. For children with and without developmental disabilities, respectively, the greatest frequencies for duration occurred in the time periods covering less than one month (37% and 35%), one to two months (16% and 9%), and twelve months (16% and 21%). Also, 1 the number of different people who committed offenses against each child was recorded in the SAIR. Among children with developmental disabilities, 46% reported abuse by a single offender and 54% reported abuse by more than one offender. Among children without developmental disabilities, 41% reported being abused by a single offender and 59% reported being abused by more than one offender. None of the findings describing the nature of the abuse presented so far were statistically significant.

Some of the reasons given for the abuse terminating for children with and without developmental disabilities, respectively, included: legal or professional intervention re: child protection (88% and 13%), victim moved away or avoided offender (47% and 53%), victim or someone else disclosed abuse (both at 50%), offender lost interest or abuse was single incident (17% and 83%), and offender moved or was removed from position or relationship (100% and 0%). The latter item was statistically significant (100%; X^2 (4) = 14.089, $p < .01$). It is possible that the very high frequency for this item in children with developmental disabilities and its absence in children without disabilities may reflect a difference in the patterns of abuse. This difference may be related to the now well-documented increased risk that a person with a developmental disability will experience abuse within the disability service system (Sobsey & Doe, 1991). The various forms of abuse disclosure for children with and without developmental disabilities, respectively, included: victim sexually or behaviorally acting out on self/others (73% and 27%), someone else told on behalf of the victim (67% and 33%), victim told mother or father substitute (59% and 41%) or family member or friend (14% and 86%), victim told in counselling (30% and 70%), and the victim told a professional outside counseling (56% and 44%). In both groups the least frequent form of abuse disclosure was the presence of medical or physical evidence. In addition, there were no significant differences for the two groups on the medically related clinical findings. Although the data presented concerning abuse characteristics is not exhaustive, the Chi-squared comparisons presented so far do not indicate significant differences between the two groups except for the reasons given for the termination of the abuse ($p < .01$). Based on this preliminary analysis it appears that certainly a number of the characteristics of the abuse experienced by the two groups of children are similar.

Results

Clinical Findings

Table 2 lists the percentages of children with developmental disabilities who were reported to exhibit various clinical symptoms. Overall, the comparative analysis suggests that most of the clinical findings recorded by the SAIR were not significantly different for children with and without developmental disabilities. Of the SAIR's numerous items, only 3 items yielded Chi square values indicating statistical significance ($p < .01$). These items included: poor sense of personal safety (44%; $X^2 (1) = 8.121$, $p < 01$), little or no age appropriate sexual knowledge (40%; $X^2 (1) = 18.769$, $p < .01$), and unkempt or dirty, or cleans or grooms excessively (19%; $X^2 (1) = 6.753$, $p < .01$).

Seven items had probabilities less than .05, though these were not statistically significant at the .01 level. These items included: inappropriate sexual remarks or comments (30%, $X^2 (1) = 4.692$, $p < .05$), withdrawal into fantasy (26%, $X^2 (1) = 4.181$, $p < .05$), self-abuse (e.g., hair pulling, head banging…) (26%, $X^2 (1) = 4.181$, $p < .05$), unusual comments about family or home life (26%, $X^2 (1) = 5.800$, $p < .05$), unkempt or dirty on a regular basis (14%, $X^2 (1) = 4.479$, $p < .05$), and extreme withdrawal at school/work/counseling (14%, $X^2 (1) = 4.479$, $p < .05$). Although not reported among the children with developmental disabilities (0%, $X^2 (1) = 4.479$, $p < .05$), a possible difference was found on the item use/abuse of substances (specifically alcohol), which was reported in 14% of the children without developmental disabilities. It is possible that the low frequency for this item in children with developmental disabilities may indicate a difference in response that may be related to reduced access to alcohol. This low frequency may represent a potential protective factor for possible substance related effects.

Table 2

SAIR Reported Findings in Children with and without Developmental Disabilities

Specific items on the SAIR	Children With developmental disabilities	 Without developmental disabilities
Aggressive/dominant behaviors	58%	47%
Poor self-esteem	53%	51%
Inappropriate anger	51%	35%
Poor sense of personal safety	44%	14% **
Nightmares	42%	37%
Little or no appropriate sexual knowledge	40%	0% **
Inappropriate sexual remarks or comments	30%	9% *
Is easily led or influenced	28%	12%
Withdraws into fantasy	26%	7% *
Self-abuse	26%	7% *
Unusual comments about home/family	26%	5% *
Unkempt or cleans excessively	19%	0%**
Unkempt/dirty on a regular basis	14%	0% *
Extreme withdrawal	14%	0% *
Uses or abuses alcohol	0%	14% *

Note. *$p < .05$. **$p < .01$.

Discussion

Similar clinical findings

Overall, clinical findings in this group of children with developmental disabilities were similar to those noted in the children in the other group. The results of this exploratory study are consistent with the hypothesis that children with developmental disabilities exhibit similar clinical findings to those documented in children without disabilities. Although there were greater frequencies for some behavioral items, these were not significant and do not provide much support for the hypothesis that there is a greater tendency for people with developmental disabilities to behaviorally communicate their distress (Dunne & Power, 1990). The relatively higher frequencies, and a few significant and non-significant findings, for items concerning sexual abuse vulnerability (e.g., poor sense of personal safety, has few friends, is easily led or influenced, etc.) provide partial support for the hypothesis that people with developmental disabilities experience additional abuse vulnerability issues (Mansell & Sobsey, in press; Tharinger et al., 1990; Westcott, 1993). The interested reader may refer to Sobsey (1994) or Westcott and Cross (1996) for more comprehensive examinations of abuse vulnerability issues. Neither the design nor the results of this study, however, provide the appropriate type of data to determine if there is support for the hypotheses that suggest abuse may exacerbate disabilities (Bowers Andrews & Veronen, 1993) or that effects are qualitatively different (Westcott, 1993).

Two of the three clinical findings that were reported significantly more frequently among children with developmental disabilities (poor sense of personal safety and little or no appropriate sexual knowledge) both appear to be related to knowledge levels. These clinical findings may represent risk factors and may be due to learning limitations imposed by developmental disability, or may reflect deficiencies in the educational programs. For example, none of the children without disabilities were reported to have had little or no appropriate sexuality knowledge for their developmental level. Although a lack of appropriate sexual knowledge is a common experience for many children with developmental disabilities, it may be more indicative of the inadequate state of sexuality education and heightened vulnerability. It is unlikely to represent an effect of sexual abuse as such, as many children who have been sexually abused display sexualized behavior and sometimes exhibit a fairly sophisticated level of sexual knowledge for their developmental level and age, due to their experience and or exposure to sexual behavior. The third finding that was reported significantly more frequently among children with developmental disabilities pertained to personal hygiene. It is unknown whether the source of this finding is a result of disability, learning experiences, response to abuse (i.e., possible symptoms related to depression or other psychological difficulties), differences in social perceptions of people with disabilities, or a combination of these.

An additional seven findings showed possible differences between the groups ($p < .05$). Considering the number of comparisons made, it would be inappropriate to consider these findings as significantly different, but equally inappropriate to consider the lack of statistical significance as a demonstration of no existing differences. Six findings were reported more frequently and one was reported less frequently in the children with developmental disabilities. Two particular items (i.e., inappropriate sexual remarks or comments, and unusual comments about home/family) may be related to social skills and learning limitations, and deficiencies in available educational programs (e.g., those related to knowledge and inadequate normative opportunities for social sexual interaction and social skill development). These may also represent a child's attempts to communicate or disclose abuse. In this study, many clinical findings were reported in similar percentages for the two groups of children. The results suggest that there are more similarities than differences in the clinical findings, however, it is important to consider the potential implications and meanings of some of these findings.

For example, some of the marginally statistically significant findings ($p < .05$), such as withdrawal into fantasy and self-abuse, may represent different kinds of responses to abuse. It may be possible that clinicians identifying effects were less likely to recognize the potential presentations of emotional difficulties in children and adolescents with developmental disabilities (e.g., diagnostic overshadowing). Suicide and suicidal behaviors are often overlooked in people with developmental disabilities (Kaminer, Feinstein, & Barret, 1987) as there may be a tendency to see these as self injurious but not suicidal. Also the tendency to withdraw may be associated with symptoms of depression, anxiety, or other psychological difficulties; however, many mental disorders may present differently in people with developmental disabilities than in the general population. Sovner (1986) notes four pathoplastic factors (i.e., intellectual distortion, cognitive disintegration, psychosocial masking, and baseline exaggeration) that can distort the presentation of mental disorders and significantly complicate the diagnostic process. Although the SAIR was judged to have both face and content validity, in view of how little is known about how sexual abuse may effect people with developmental disabilities, it is certainly possible that it may have lacked the sensitivity to this potential response variability in the clinical findings. Additional dual diagnosis research is needed to further elaborate diagnostic processes, issues, and the possible presentations of psychological problems and abuse-related difficulties in people with developmental disabilities.

Greater number of clinical findings

Differences in specific findings were small and mostly equivocal; however, more children with developmental disabilities were reported to exhibit clinical findings in 18 of 21 categories. Greater frequency for most of these was not statistically significant. This finding may represent a response difference that suggests that children with developmental disabilities exhibit a greater number of difficulties and could provide some support for the hypothesis that effects may be more complicated. For example, it is possible that the increase in the number of clinical findings may be due to the influence of psychosocial risk factors related to the developmental disability. Therefore, it is possible that clinicians working with sexually abused people with developmental disabilities may come across a greater number of clinical findings that require treatment. Some of the increase in clinical findings may be the result of conditions related primarily to the developmental disability and others may represent an increased reaction to abuse, but research will be required to determine which of these is the primary influence. Further dual-diagnosis research considering the base rates of behavior and psychological problems in people with developmental disabilities, who have and do not have a history of sexual abuse, may help researchers determine if, and how, sexual abuse may modify these. This difference may suggest research areas to examine the possible influences of disability-related issues on effects (e.g., possessing fewer resiliency enhancing factors, having difficulty with coping, poor self-esteem, greater vulnerability to developing psychological difficulties, social isolation, etc.). Most clinical findings occurred with greater frequency in the children with developmental disabilities and the clinical findings between the two groups of children were overwhelmingly similar, but most differences were not statistically significant.

Limitations

The design of this study has some limitations. To determine the similarities or differences in the clinical findings in the two groups, the researchers used a comparison group of children and adolescents receiving treatment who did not have disabilities. Unfortunately, in this research design, a community based, control group of children, with and without developmental disabilities, who were not sexually abused, was not available to the researchers. Using the SAIR with such an appropriate control group would have ensured a more rigorous research design and its absence presents a limitation to the conclusions that can be drawn from the study. Although the items for the SAIR were developed to provide a record of the clinical findings associated with child sexual abuse, without an additional source of comparison (i.e., the use of a control group of nonsexually abused children), it remains unclear how specific, or discriminating, the clinical findings items in the SAIR are to sexual abuse. The use of such an additional control group may have indicated if children who had, and children who had not been sexually abused respond differently to the items on the SAIR. Future research should use larger controlled samples to study both children with and without developmental disabilities. Studying samples of such children who have substantiated child sexual abuse and those who have not been sexually abused can further contribute to our understanding of potential sexual abuse effects in children with developmental disabilities.

Although much of the information describing the abuse experienced suggests these experiences were very similar for the two groups, unfortunately little was available concerning the actual outcomes of the abuse investigations for the children in this sample. In the absence of much of this critical information, it is difficult to determine what proportion of the sample had substantiated sexual abuse. Therefore, some caution is required because it may be difficult to interpret the results of the clinical findings as being effects of sexual abuse when sexual abuse has not been substantiated. Also, all the children in this nonrandom sample were restricted to those receiving treatment for child sexual abuse at one treatment center over a two year period. Therefore, the results may not necessarily be representative of children and adolescents who do not receive treatment or even those receiving treatment at other centers. The conclusions drawn from this exploratory study are limited and can only be generalized to the clinical findings or treatment issues of children receiving treatment who are similar to those described in the sample.

Conclusion

With the increasing recognition of the mental health needs and heightened risk for sexual abuse in people with developmental disabilities, more professionals working in this area need to be aware of the effects of sexual abuse in this vulnerable group, for the development of detection and treatment strategies. Although the results of this exploratory study suggest that the clinical findings in children and adolescents with and without developmental disabilities are similar and consistent with research literature, this area of study is in its early stages. Not enough is yet known to determine whether or not there are specific similarities or differences in the effects of child sexual abuse in people with developmental disabilities.

The traditional child sexual abuse effects research provides an important foundation for our understanding. The research pertaining to these effects in people with developmental disabilities, however, illustrates the necessity of building on this foundation and further integrating it with the research and clinical knowledge from the developmental disability, mental health, and dual-diagnosis-related disciplines. There remains an enormous amount of clinical research to be conducted, to learn more about the influence of mental retardation on the presentation, diagnostic process, assessment, and treatment of mental disorders. The growing dual-diagnosis-research literature holds significant promise for helping researchers and clinicians learn about the interactions that can occur between developmental disability and the variable psychological problems associated with child sexual abuse. Integrating the research findings from the dual diagnosis and sexual abuse trauma effects and assessment literatures may help promote the development of, or revisions of existing, trauma related measures such as the SAIR. Also, further research may provide valuable clinical information for clinicians providing treatment services to children and adults with developmental disabilities. Clinicians need to consider the multiplicative impacts of developmental disability and associated mental health issues, vulnerability to abuse, and diagnostic issues on the presentations of sexual-abuse-related trauma in order to identify treatment issues and provide appropriate, responsive treatment.

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CHAPTER 3.

Therapy Accommodations for Treating Sexual Abuse in Clients with Developmental Disabilities: Results of an International Survey

ABSTRACT

People with developmental disabilities have a heightened risk for sexual abuse compared to their non-disabled peers, however, therapy services often are inaccessible, unavailable, or inappropriately adapted to meet their needs. Little is known about specific counselling accommodations and treatment components that are used for treating sexual abuse in this vulnerable group because there is a paucity of research and appropriately trained professionals. The literature on sexual abuse treatment issues, treatment considerations, and the varied therapy accommodations that are used for people with developmental disabilities who have been sexually abused, is reviewed. This literature also was consulted for the development of a survey of professionals. Selected results from an international survey of professionals, who provide therapy services to people with developmental disabilities who have been sexually abused, are presented and discussed. Also the implications for professional training and the provision of treatment services are discussed.

Therapy Accommodations for Treating Sexual Abuse in Clients with Developmental Disabilities: Results of an International Survey

The findings of numerous research studies and reviews indicate that both adults and children with developmental disabilities have a heightened risk for sexual abuse (Ammerman, Van Hasselt, Hersen, McGonigle, & Lubetsky, 1989; Crosse, Kaye, & Ratnofsky, 1993; McCabe & Cummins, 1993; Sobsey, 1994; Sullivan & Knutson, 1994; Turk & Brown, 1992). One American study indicates that children with disabilities are 1.67 times as likely as other children to be abused (Crosse et al., 1993). Sullivan and Knutson (1994) reported mental retardation in 6.2% of their sample of 2845 abused children, but only in 1.3% of their control group of 880 non-abused children. Abused children were 4.8 times as likely to be mentally retarded. One comparative study found that people with mild mental retardation were 3.6 times more likely to have been raped and 1.8 times more likely to have had sexual contact with a relative than people without disabilities (McCabe & Cummins, 1993).

The effects of child sexual abuse

There is extensive literature documenting the effects of sexual abuse in the general population (Briere, 1992; Browne & Finkelhor, 1986; Kendall-Tackett, Meyers-Williams, & Finkelhor, 1993), however, there has been little research about its effects in people with developmental disabilities. Some authors suggest that the issues in treating sexual abuse in people with developmental disabilities are similar (Cruz, Price-Williams, & Andron, 1988; Gorman-Smith & Matson, 1992) to those noted in the general child sexual abuse literature. However, dual-diagnosis research (i.e., mental retardation and mental disorder) indicates that people with developmental disabilities are more likely to suffer psychological disturbances than the general population (Borthwick-Duffy, 1994), and that various pathoplastic factors associated with mental retardation can distort the presentation of mental disorders and complicate diagnosis (Sovner, 1986). Some researchers assert that responses are intensified or qualitatively different (Gorman-Smith & Matson, 1992;

Mansell & Sobsey, in press; Martorana, 1985; Varley, 1984; Westcott, 1993) because of developmental disability related issues (e.g., low self-esteem, poor social and communication skills, inadequate access to normative relationships and sexual experiences, limited sexuality knowledge, prolonged dependency, negative feelings associated with having a developmental disability, and vulnerability to abuse). Some authors assert that there may be greater behavioral difficulties (Dunne & Power, 1990) or worsening of disabilities (Bowers Andrews & Veronen, 1993). Most of this literature is speculative, however, and there has not yet been sufficient study to determine if there are atypical sexual abuse effects (Mansell, Sobsey, & Moskal, in press).

Traditionally, professionals' pessimism about the ability of people with developmental disabilities to participate in or benefit from traditional therapies, the misattribution of psychological problems to developmental disability (Levitan & Reiss, 1983), and other barriers have inhibited therapy research and practice. In more recent years, however, there has been growth in professional organizations, conferences, specialized research projects, and publications that examine mental health problems and the use of various therapies with people with developmental disabilities. Despite acknowledgment of this vulnerable group's heightened risk for both sexual abuse and mental health problems, and professionals' increasing receptiveness to adapt conventional therapies, therapy services to treat sexual abuse are often inaccessible, unavailable, or inappropriately adapted (Mansell, Sobsey, & Calder, 1992). In addition, little is known about the accommodations professionals use to ensure that therapy is appropriate.

In this study, the researcher reviewed the literature covering therapy accommodations and sexual-abuse-related treatment components. A survey of professionals who provide treatment services to people with developmental disabilities, who have been sexually abused, was developed and is based on that review. In this paper, selected results from this study will be presented. Emphasis is placed on the accommodations and sexual-abuse-related treatment components professionals use, the clients they serve, and the problems they encounter. A discussion of the implications for professional training and research concludes this paper.

Adapted therapy

Over the years, practitioners reported varying degrees of success with adapted therapies that include: individual (Blotzer & Ruth, 1995; Hurley, 1989; Spackman, Grigel, & MacFarlane, 1990; Thompson Prout & Cale, 1994), psychodynamic (Alvarez, 1992), group (Brown, 1994; Tomasulo, 1990), art (Caprio-Orsini, 1996), play (Baum, 1994; Caton, 1988), and family therapies (Cobb & Gunn, 1994; Gapen & Knoll, 1992). Therapies have been implemented to treat sexual abuse in children (Burke & Gilmour, 1993; Perlman & Sinclair, 1992; Sullivan, Scanlon, Knutson, Brookhouser, & Schulte, 1992) and adults (Cruz, Price-Williams, & Andron, 1988; Hyman, 1993; Ryan, 1992) with developmental disabilities. The degree to which authors emphasize this therapy's distinctiveness varies. Although most authors suggest that the therapy approaches resemble those used with people without disabilities, others emphasize the distinct considerations involved. Therapist's accommodations refer to changes a therapist makes to ensure that therapy is appropriate for the client's developmental level and his or her language, communication, and comprehension abilities (Hurley, 1989).

Treatment considerations

Therapists need to actively consider: the psychological impact of the client's socialization and disempowered status; the influence of their caregivers and atypical living experiences; and the impact that differing levels of cognitive and communicative functioning have in therapy. People with developmental disabilities are extremely heterogeneous in terms of their disabilities and coping abilities and this presents distinct challenges. Therapists require considerable knowledge about developmental and other forms of disabilities and the psychology of handicapping conditions (Sullivan & Scanlan, 1987). It is critical that therapists be sensitive and responsive to developmental-disability-related issues and the implications these have for selecting and implementing therapies (Mansell, 1996).

Therapists need to be cognizant that there can be considerable gaps between a client's expressive and receptive language, comprehension, and abstract reasoning ability. A person may: have difficulty understanding causal relations; have poor short term memory; lack an awareness that he or she can help him or herself; and use only part of the relevant environmental cues in problem solving. There can be problems interpreting social situations, perspective taking, and recognizing and labeling emotions in oneself and others (Brown, 1994). Cognitive processes are often concrete and bound to the particular (i.e., focusing on what is directly knowable in the immediate present situation). The nature of these cognitive processes suggests that there are likely to be difficulties associated with the ability to generalize learning to other settings, monitor or evaluate the results of a solution strategy, and consider consequences. The variable nature of a client's cognitive characteristics suggests that therapists need to actively consider exactly what the client understands and how he or she communicates about their understanding or experience of the world and social relationships. It is also important to consider how a client views him or herself in terms of his or her own agency to solve problems. The considerable heterogeneity, both in terms of clients' strengths and difficulties, requires that therapists adapt their interview and therapy techniques to clients' cognitive, communicative, and developmental levels (Hurley, Pfadt, Tomasulo, & Gardner, 1996; Hurley, 1989; Reiss, 1994; Thompson Prout & Strohmer, 1994a). Also therapists should appreciate that clients may feel overwhelmed and ill-equipped for the conversational demands of verbal psychotherapy. Therefore, therapists may need to provide specific education or training to prepare the client for therapy (Keller, 1996).

Preparation for therapy

Therapy preparation can include assessing the client's affective vocabulary, teaching the distinction between thoughts and feelings, and introducing different avenues and activities to foster emotional expression (Thompson Prout & Strohmer, 1994a). Many clients may learn the required skills with some practice, when the therapist communicates the value of the client's views and a willingness to listen to and learn from the client (Thompson Prout & Cale, 1994). Early on, it is crucial that the therapist talk about the purpose of meeting, determine if the client understands why he or she is coming to therapy, and provide clarity about the roles, responsibilities, scope of the therapy relationship, and termination (Mansell & Sobsey, in press). The use of preparation for counselling underscores the importance that clients understand the purpose of counselling, as clients may have misconceptions about why they are in therapy. For example, people may believe that their referral after a sexual assault is some form of punishment for having done something wrong. Therapy preparation can help address misconceptions about therapy and demystify the process. It can also help the client focus on specific treatment goals (Keller, 1996).

Goal setting and working systemically

Many authors encourage setting goals that are restricted to resolving specific, concrete, real life problems, and use techniques that promote development of direct problem solving skills (e.g., role-play and modeling) (Thompson Prout & Strohmer, 1994a). Other authors suggest that therapists be more directive and use more structured sessions and more active therapeutic styles (Hurley, 1989; Thompson Prout & Strohmer, 1994a). Therapists also need to be supportive and flexible and to consider alternative techniques and simpler ways to approach therapy (Hurley, 1989). Working with the client's system (e.g., his or her living environment and significant others) can help the therapist monitor treatment outcome and can promote greater long term learning and behavioral change. Therapists need to be cautious about potential conflicts that can arise between the client and the system, in terms of therapy goals and expectations. Conflicts sometimes concern issues such as: determining exactly who has the "problem" requiring treatment (e.g., if a client has some assertive behaviors that are deemed as undesirable, defiant or non-compliant by a particular caregiver etc.), to whom is the therapist providing service (e.g., the client, the client's family, or the system), and whose interests are to be protected and served in this process (e.g., ensuring client confidentiality). Providing early clarification to the various parties about their roles, responsibilities, and boundaries, in these relationships can be crucial to addressing some of these potential difficulties (Reiss, 1994).

Repetition and teaching

Because therapy may involve teaching new concepts, the therapist may need to restrict the number of issues addressed in sessions and to use repetition and appropriate educational materials (e.g., videos, books, and other materials) that communicate ideas more concretely (Mansell, 1996). Reviewing previous sessions at the beginning of a session can also provide a helpful prompt (Gorman-Smith & Matson, 1992) because therapists must be cautious about assuming the client's ability to recall previous discussions or to generalize concepts learned in therapy. Clients require ongoing support outside of therapy, that can be provided through additional opportunities for generalizing concepts and practicing behaviors and techniques learned in therapy. Engaging the system to obtain both support and cooperation for the client's therapy goals can increase the likelihood of achieving lasting behavioral changes. It also requires that therapists resist pressures from the system and exercise appropriate respect for clients' privacy and confidentiality.

Communication

Communication can be a complicated process as many people with developmental disabilities have a tendency to provide information in a piecemeal manner, to omit necessary information, to include irrelevant details, or to voice incomplete or unconnected thoughts (Kernan & Sabsay, 1989). Therefore, therapists may need to offer hypotheses and use a greater number of reflecting, pacing, and leading comments. Ongoing clarification of a client's statements may help the client become more specific in communicating his or her experiences (Thompson Prout & Cale, 1994). Also, therapists must determine what the client means by his or her language, if he or she understands the therapist (Thompson Prout & Strohmer, 1994b), and be sensitive to the possibility that clients may feign understanding.

The most common expressive language difficulties include: articulation, speech fluency, restricted vocabulary, and inadequate conversation skills (Brown, 1994). Receptive language ability often exceeds expressive language and many people understand more than they can express. The therapist needs to understand the client's patterns of delays and strengths in receptive and expressive abilities, idiosyncratic language, and non-verbal communication. Sensitivity to and perceptiveness of the varied meanings attached to body language, eye contact, posture, facial expressions, gestures, vocalizations, and tone of voice provide salient information about client communications (Mansell & Sobsey, in press). Consultation with caregivers, and professionals directly involved and well-acquainted with the client's communication difficulties, as well as formal assessments, are invaluable for guiding communication practices.

The therapist needs to alter his or her communication style to match the client's communication ability. Therapists who are trained in highly abstract, verbal therapies may need to engage in an active translation process to make their language more concrete and their sentences simpler (Mansell & Sobsey, in press). It may be preferable to use concrete language, Plain English (i.e., simple short sentences), avoid the use of double negatives, euphemisms, slang, or jargon, and use briefer, more directly answerable questions (Thompson Prout & Strohmer, 1994). It is crucial that therapists be familiar with the various communication alternatives, and non-verbal therapies, and be willing to seek consultation to adapt therapy to client's cognitive, attention span, and receptive and expressive language abilities (Thompson Prout & Strohmer, 1994b).

Problems professionals encounter

There are numerous considerations in adapting therapy, and professionals indicate that this practice is not without its problems. Westcott's (1992) survey of child abuse professionals working with children with developmental disabilities, outlined difficulties that included: problems with interagency cooperation, the sense that no one wanted to take responsibility for the children, antagonistic responses from family, families' refusal to recognize the child's disability, and problems obtaining adequate resources and specialist advice. Professionals also reported therapy accommodation related difficulties such as trying to find the right level at which to work with the child, attempting to gauge how much a child could understand, and making allowances for the child's reduced attention span (Westcott, 1992). This survey indicated the significance of both systemic and adaptation-related difficulties for these professionals.

Treatment components for sexual abuse related issues

Specific therapy components should take into consideration a client's treatment and disability related issues, social circumstances, and the varied factors that contribute to his or her heightened vulnerability to sexual abuse. Distinct components for addressing these and other related concerns may include: the development of self-protection skills, that therapists assess and expand clients' affective vocabulary (Ludwig & Hingsburger, 1989; Sullivan, 1993), help clients develop social and sexuality skills, teach about sexual abuse and self-protection skills (Mansell & Sobsey, in press), address self-esteem (Ludwig & Hingsburger, 1993) and disability related issues (Hurley, 1989; Szivos & Griffiths, 1992), and treat any secondary behavior problems (Sullivan et al., 1992).

Therapist's accommodations survey

Survey development

Thus far, although there has been growing interest in this area, there have been almost no descriptive studies that indicate professionals' therapy practices, the problems they encounter (with the exception of Westcott [1992]), or what factors may influence their use of particular accommodations or treatment components with clients who have varying degrees of developmental disabilities. In this study, the literature covering therapist's accommodations, components used to treat sexual-abuse-related issues, and professionals' reported difficulties in providing these services, were consulted and informed the researcher's development of the survey. This study used a survey method to obtain (1) more detailed, descriptive information about professionals' training and experience, and the specific therapy devices, techniques, accommodations, and components that professionals use, (2) more descriptive information about the characteristics of people with differing degrees and varieties of disabilities who receive adapted therapy services, and (3) greater clarity about problems encountered by these professionals.

Method

Potential participants were targeted and selected for inclusion because they were either known by reputation to possess expertise in this area (i.e., they had published articles or presented at conferences on this subject), had considerable experience, were known by the researcher to be providing therapy services to people with developmental disabilities, or had professional affiliations that might promote appropriate survey distribution. Participants were selected from membership listings of the National Association for Prevention of Sexual Abuse of Children and Adults with Learning Disabilities (NAPSAC) in the United Kingdom, the National Coalition on Abuse and Disability (NCAD), and the National Association of the Dually Diagnosed (NADD) in the United States, the Sexual Abuse and Young People with Disabilities Project (SAYPD) in Canada, and the University Affiliated Programs (UAP) in the United States, among other sources. Participants were contacted by mail, sent a cover letter describing the study, a survey, and a self-addressed, stamped envelope. (See Appendices D and E for the study's cover letter and the survey). All survey responses were confidential and respondents were asked to preserve their clients' confidentiality by avoiding the use of any names or identifying information.

The first part of the survey requested information about professional training, highest level of education, professional title, country of practice, specialized communication training, amount of experience, and the therapeutic approaches that best describe their practice. Respondents also were asked to describe the clientele with whom they most typically conduct therapy (i.e., age, gender, level and type(s) of disability). Survey respondents were asked to describe difficulties that they encounter, the therapeutic accommodations they use, and the specific therapy techniques or components they use to treat sexual abuse related issues. This study is primarily exploratory and descriptive. Therefore, no restrictions were placed on the number of categories respondents could use. Most variables are described using multiple categories; therefore, there is considerable overlap. Additional spaces were provided for respondents' comments and, where possible, this supplemental information is summarized.

Over 300 surveys were sent out and 105 with usable data were returned within a three month period. A number of surveys were returned due to address problems and some respondents indicated that they could not respond because they felt that they lacked the expertise required and informed us that they distributed it to others they felt were better qualified to answer the survey. Therefore, it is difficult to determine either the response rate or the representativeness of the respondents. In the latter case, the responses of a self-selecting, non-random sample may not be representative of professionals providing this service, who either chose not to respond or were not targeted as potential participants.

Sample

Specialization, educational level, and experience

Many respondents reported that they practiced in the UK (39%) and the US (35%). Nineteen percent reported practicing in Canada and a substantially smaller proportion reported practicing in Australia (4%), and other countries (2%). There was considerable diversity in respondents' professional disciplines and training, level of education, and amount of experience. There was representation from the medical, mental health, and mental disability disciplines (e.g., respondents included psychiatrists, psychologists, social workers, professors, art and behavior therapists, nurses, occupational therapists, etc.). The largest proportions of respondents reported that their training was in psychology (55%), social work (27%), and special education (19%). Far fewer respondents reported receiving training in disciplines such as nursing (11%), other specializations (e.g., sexuality educator, psychotherapist, behavioral or art therapist) (10%), rehabilitation (9%), and psychiatry (6%). Close to seventy-five percent of respondents reported having graduate level training (e.g., Masters [48%], Doctoral [25%[, or Post-Doctoral degrees [1%]). Twenty percent of respondents had Bachelors degrees, 5 percent had various diplomas, and 1 percent had other education. The number of years experience ranged from less than a year to 37 years with a mean of 11.5 years and a standard deviation of 7.56 years. Most respondents had considerable professional training and experience in their chosen disciplines, and many respondents were trained in more than one discipline, which suggests a multidisciplinary orientation in this sample.

Therapeutic approaches

Respondents identified the therapeutic approaches that most represented their therapy work. A large majority of respondents identified their therapeutic approach as cognitive behavioral (62%) (e.g., using rational emotive techniques). Fifty-six percent of the respondents identified their therapeutic approach as behavioral (e.g., using social skills training, discrete trial training, functional analysis and functional communication training, gentle teaching, etc.), 54 percent identified their approach as eclectic, and 49 percent identified their approach as client-centered. Thrity-five percent identified their approach as psychoeducational (e.g., human development and sexuality, abuse risk reduction), 31 percent identified their approach as family systems, and 26 percent identified their approach as psychodynamic. Twenty-five percent identified using "other" approaches (e.g., attachment based analytic, gestalt, integrated sex therapy, narrative, solution focused, systems therapy, transactional analysis, biopsychosocial, hypnotherapy, psychodrama, etc.) Less frequently identified approaches included feminist (14%), object relations (5%), and self- psychology (4%). Almost all respondents identified using more than one therapeutic approach, and many respondents reported using a variety of therapy modalities. Frequently used modalities included individual and group therapies, and somewhat less frequently used modalities included family (e.g., family, couple, and systems), educational (e.g., development of social relationships), and expressive modalities (e.g., art, play, sand, and movement therapies).

The diversity in the therapy approaches and the modalities used by this sample may reflect the general trends in mental health and disability related services, toward increasing flexibility and reduced adherence to a singular approach. It may also reflect the interactions between the diverse disciplines involved in providing these services. It is also consistent with the recommendations from the literature that professionals working with clients with developmental disabilities be flexible and responsive, and underscores the importance of drawing from diverse therapeutic and disciplinary practices to meet client's needs. A description of the clients who receive these services, from this sample, follows and precedes a more detailed description of professionals' use of therapy accommodations and treatment components.

Characteristics of clients

Respondents described the characteristics of the clients with whom they had the most experience. The majority of respondents served both males and females (92%), however, small but equal proportions (4%) reported that they served either males or females. The majority of respondents reported that their clients were: young adults, between 20-30 years (71%), middle age adults, between 30-50 years (64%), and middle to late adolescents, between 15-20 years (41%). Smaller proportions of respondents reported that their clients were: in the middle childhood years, between 5-10 years (29%), in early adolescence, between 10-15 years (29%), and in later middle age, between 50-60 years (22%). Clients who were either in their early childhood years, between 0-5 years 16%), or in their later adulthood years, being 60 years and older (13%), were the two least likely age groups to receive therapy services from this sample of professionals.

Level of intellectual ability and additional types of disability

Respondents also reported their clients' level of cognitive functioning and the nature of any other type(s) of disabilities. Seventy-four percent and 71%, respectively, indicated that their clients' cognitive functioning was within the mild or moderate range of developmental disability. Four percent and 2% of respondents, respectively, indicated that their clients' cognitive functioning was within the severe or profound ranges. The most frequent client disabilities included mental/intellectual (85%), psychiatric/ psychological (70%), and communication disabilities (60%). Less frequently identified disabilities included motor (52%), multiple (53%), and sensory (39%) disabilities. The adapted therapy literature, overall, provides more documentation of therapy conducted with mild and moderate range clients, than for clients functioning within the severe or profound ranges of developmental disability. The proportions of clients who were reported to be served by this sample were consistent with this. Based on the literature on adapted therapy and professionals' perceptions about the efficacy of this therapy, it seems reasonable to expect that clients' level of intellectual disability and the presence of additional disabilities will influence the frequency with which varying client groups receive treatment. It may also be possible that the nature and severity of clients' disabilities may be related to professionals' specialized disability-related training, and the frequency with which professionals use various types of therapy accommodations.

Results

Specialized communication training

Respondents were asked if they had any specialized communication training that included: use of alternative symbol systems (e.g., PIC, Bliss, Makaton, etc.), electronic communication devices (e.g., Computers), sign language (e.g., ASL, BSL, CSL, etc.), non-electronic communication devices (e.g., Communication boards), or other. Thirty-one percent of respondents indicated that they were trained in the use of alternative symbol systems, 29 percent in sign language, 25 percent in electronic devices, and 24 percent in non-electronic devices. A smaller proportion (9%) of respondents had other training (e.g., Somerset total communication system, signed English, facilitated communication, and Derbyshire language scheme training), and nearly 40 percent reported that they had no specialized communications training.

There was some variation in the types of communication training that professionals had, and the clients with whom they reported to have the most experience in providing treatment. However, in some cases, there did not appear to be any differences between the professionals with and without communications training in terms of the clients they served. The "other" category was consistently lower across all disabilities than the previously mentioned communication training categories. The various specialized communication training categories are summarized in terms of the percentages of clients with varying disabilities that respondents reported serving.

There were no notable differences in the percentages of clients with mild and moderate intellectual disabilities, who were served by respondents with specialized communication training (i.e., percentages ranged from the low twenties to low thirties). Comparatively, the proportion of clients with severe and profound intellectual disabilities was higher and more variable (i.e., percentages ranged from the low thirties to the mid-sixties) than for those who served clients in the mild or moderate ranges. Overall, there were no notable differences in the percentages for respondents who served clients with mental/intellectual disabilities, motor, communication, psychiatric/psychological, and multiple disabilities (i.e., the percentages ranged from the mid twenties to the mid-thirties). The largest percentages and variability, however, were noted for the respondents serving clients with sensory disabilities (i.e., the percentages ranged from the mid-thirties to the low fifties).

Also, of the respondents who indicated they did not have any specialized communication training, 42 percent and 40 percent, respectively, reported that they served clients with mild and moderate intellectual disabilities. Smaller percentages of these respondents reported serving clients with severe (26%) or profound (12%) intellectual disabilities. The percentages for respondents who served clients with mental/intellectual disabilities, motor, communication, and psychiatric/psychological disabilities ranged from the low to high thirties. Somewhat smaller percentages were noted for the client groups having sensory (24%) or multiple disabilities (29%).

For these professionals, it appears that having specialized communication training may have some relationship to the types of clients that they are more likely to serve. For example, professionals without specialized communication training appear less likely to typically provide therapy services to clients who have either severe or profound intellectual or sensory disabilities. Alternately, professionals who reported the largest percentages across all of the specialized communication training categories were more likely to report providing services to clients with severe intellectual disabilities (range from 30% to 44%), sensory disabilities (range from 34% to 51%) and profound intellectual disabilities (range from 42% to 65%). Specialized communication training appeared less likely to influence whether or not these professionals served clients with either mild or moderate intellectual disabilities, or with mental/intellectual, motor, communication, psychiatric/psychological or multiple disabilities.

Therapy accommodations and disability

Respondents reported the therapy accommodations they use to enhance client and therapist communication and comprehension, and therapy appropriateness. The results are presented from the least to most frequently used, and the accommodations are separated into categories that include (1) devices or techniques and (2) accommodations. Respondents' use of these is examined in relation to the type and level of intellectual disability of the clients served by these respondents.

Specific devices or techniques

Devices or techniques included the use of electronic assistive communication devices (e.g., computers), non-electronic assistive communication devices (e.g., communication boards), projective techniques, special symbol systems (e.g., Bliss, PIC, Makaton), sign language (e.g., ASL, BSL), speech/lip reading, and a translator or interpreter who is familiar with client's communication style. Speech/lip-reading was the least frequently used technique. This technique was used by less than ten percent of respondents for all of the categories of clients with disabilities who were served (e.g., the percentages ranged from two percent for clients with severe intellectual disabilities to seven percent for clients with sensory disabilities). Both projective techniques and special symbol systems were used with greater frequency than speech/lip reading and used in approximately equal proportions by respondents for all the client disability groups (i.e., ranging between mid-teens to mid-twenties). Sign language was used in similar proportions by respondents for all the client disability groups (i.e., the percentages ranged between high teens to mid-twenties). Sign language was used more frequently, however, for clients described as having profound intellectual disabilities (35%) and sensory disabilities (39%).

Electronic devices were used in approximately equal proportions (i.e., percentages ranged between mid-twenties to low thirties) by respondents for all the client disability groups. Electronic devices were used more frequently, however, by respondents who reported serving clients described as having either sensory (37%) or motor disabilities (40%). Non-electronic devices were used in similar proportions by respondents for all the client disability groups (i.e., percentages ranged between the middle to high thirties). The most frequent use of non-electronic devices, however, was reported by respondents serving clients described as having communication (43%), severe intellectual disabilities (48%), sensory (49%), and multiple disabilities (50%).

The use of a translator or interpreter who is familiar with client's communication style was the most frequently reported technique used by respondents across all client groups (i.e., percentages ranged between mid-thirties to mid-forties). This technique was used in approximately equal proportions of respondents serving clients described as having mental/intellectual disabilities; mild, moderate, and profound intellectual disabilities; or psychiatric/psychological impairments (i.e., percentages ranging from the middle to high thirties). Slightly larger proportions, however, were reported for clients described as having communication disabilities; severe intellectual disabilities; multiple, motor, and sensory disabilities (i.e., percentages ranged from low forties to mid-forties).

Specific accommodations

The specific accommodations included the use of concrete language, plain English, less verbally oriented therapies (e.g., play, art, sand, dolls), providing additional time for the client to respond, learning the client's non-verbal communication style (e.g., clients' use of non-verbal [body] language, idiosyncrasies, and gestures), learning the client's verbal communication style (e.g., clients' use of intonation, articulation, speech patterns, idiosyncrasies), and "other" accommodations of which respondents provided numerous examples. A sampling of these included the use of music, movement, concrete materials and models, pictures, and the use of video demonstration and feedback, using shorter, more structured and goal focused sessions, environmental accommodation, on site visits, behavioral incentives, facilitated communication, the use of inclusive practices, behavior practice and role play, repetition, and providing support to staff who work with the client, among others. Tables 3 and 4 provide descriptions of the percentages of respondents who reported serving clients with differing levels and types of disabilities using the various therapy accommodations.

The "other" accommodations were the least frequently used by respondents across all categories of clients' disabilities. Most proportions ranged from the low twenties to low thirties, however, the category of profound intellectual disability was substantially lower than the other disability categories.

The proportions reported for the use of less verbally oriented therapies ranged between the low fifties to low seventies with most of the percentages clustered around the high sixties. The use of less verbally oriented therapies was the least frequently used accommodation reported by respondents who served clients with moderate intellectual disability (58%), but the most frequently used accommodation by those respondents who were serving clients with psychiatric/psychological disabilities (70%).

Accommodations that include learning the client's verbal communication style, providing additional time for the client to respond, learning the client's non-verbal communication style, the use of concrete language, and plain English were used by a substantial proportion of respondents. The proportions for learning the client's verbal communication style ranged between the high sixties and the high eighties. Learning the client's verbal communication style was the least frequently used accommodation by respondents serving clients with profound (69%) and moderate (68%) intellectual disability and the most frequently used accommodation reported by respondents serving clients with multiple disabilities (86%). Although a substantial proportion of the respondents reported learning client's non-verbal communication style (i.e., percentages ranged between the low eighties to the mid-nineties), this was the least frequently used accommodation reported by respondents serving clients with mild (80%) and moderate (81%) intellectual disability, and mental/intellectual disability (84%). It was the most frequently used accommodation reported by respondents serving clients with motor and multiple disabilities (i.e., both percentages exceeded 90%). Providing additional time for the client to respond was used by substantial proportions of respondents. Although proportions ranged between the low eighties to the high nineties, it was the least frequently used accommodation reported by respondents serving clients with severe (86%) and profound intellectual disabilities (81%) and the most frequently used accommodation reported by those who served clients with multiple (93%), sensory (93%), and motor disabilities (98%). The use of concrete language and plain English were the most frequently used accommodations reported by respondents across all categories of clients' disabilities. The proportions ranged between the mid-eighties to mid-nineties, and high eighties to mid-nineties, respectively.

Therapy techniques and components

Respondents were asked to provide information about therapy techniques and components they use. The different techniques and components include those used to enhance the effectiveness of therapy, to reduce the client's vulnerability to sexual abuse, and to address sexual-abuse-related effects. Many respondents indicated they used components to enhance the efficacy of the therapy. A large proportion of respondents reported that they worked systemically and enlisted parents/guardians or staff for support where appropriate (77%), used pre-therapy preparation or relationship-building techniques (66%), and psycho-educational techniques and repetition to teach specific concepts (60%). Fifty-four percent reported using more directive approaches to maintain focus and structure in therapy and 51% reported using psychoeducational approaches to teach clients an affective vocabulary.

Many respondents also indicated that they used therapy components to help reduce their client's vulnerability to sexual abuse. Seventy-three percent reported using social skills/sexuality education, 69% reported using sexual abuse risk reduction education, and 68% taught assertiveness training. Forty-nine percent reported using therapy components that teach or enhance communication skills, and forty-one percent used *in vivo* training to promote concept generalization outside therapy.

Many respondents indicated that they used differing therapy components to address their clients' sexual abuse related effects. Eighty-six percent indicated that they treated poor self-esteem, and 71% reported that they treated developmental disability issues. Sixty-one percent of respondents indicated using behavioral approaches for secondary behavior problems (e.g., inappropriate sexualized or aggressive behavior), twenty-seven percent reported using empathy training, and 21% reported using gentle teaching. Seventeen percent reported using other components such as teaching about boundaries, educating staff and others about confidentiality, problem solving, self-advocacy, and independence training. It would appear that clients' specific treatment issues would influence, in varying degrees, therapists use of these different treatment components.

Problems

Problems encountered by professionals included adapting communication style to meet client's communication and comprehension needs in therapy (55%), inadequate professional and financial support for therapy programs (50%), and eliciting cooperation from staff or family members for therapy (50%). Thirty-seven percent of respondents reported difficulties with adapting the therapist's communication style to meet client's communication and comprehension needs for assessment purposes, and 33% reported difficulties with matching therapy techniques flexibly and creatively. Respondents reported having difficulties obtaining adequate psychoeducational or resource materials for use in therapy (21%), access to communication alternatives for therapy (20%), and "other" problems (21%). Many respondents' comments about these other problems reflect concerns with actually adapting therapy, securing appropriate sexuality educational and testing materials for use in therapy, and receiving collegial validation, specialized communication training, and supervision. Additional concerns included overcoming professional, attitudinal, and financial barriers to providing treatment (e.g.,

Table 3

Therapy accommodations used by therapists working with clients with developmental disabilities

Therapy accommodations	Clients with developmental disabilities			
	Mild	Moderate	Severe	Profound
Concrete language	89%	85%	88%	85%
Plain English	95%	93%	94%	92%
Less verbally oriented therapies	64%	58%	66%	69%
Learn client's verbal communication	71%	68%	76%	69%
Learn client's non-verbal communication	80%	81%	86%	85%
Additional time	90%	91%	86%	81%
Other	27%	23%	24%	12%

Table 4

Therapy accommodations used by therapists working with clients with various disabilities

Therapy accommodations	Clients with other disabilities					
	Sensory	Motor	Mental	Multiple	Communication	Psychiatric
Concrete language	93%	95%	88%	92%	89%	85%
Plain English	88%	95%	93%	96%	95%	93%
Less verbally oriented therapies	66%	69%	63%	68%	68%	70%
Learn client's verbal communication	73%	78%	71%	86%	73%	71%
Learn client's non-verbal communication	88%	91%	84%	95%	87%	84%
Provide additional time	93%	98%	89%	93%	92%	88%
Other	29%	27%	25%	34%	27%	27%

lack of time and money required for providing treatment or interpreters, lack of collegial support, and building accessibility), working with the legal system, and securing cooperation for treatment from the client's system and maintaining confidentiality between clients and staff. Concerns noted by profesionals in this study appear to correspond to and expand on some of the issues noted in Westcott's study (1992). These problems have numerous implications for professional training that may increase treatment accessibility, availability, and appropriateness for people with developmental disabilities.

Discussion

The results of this preliminary study suggest that many respondents providing these services had considerable professional training and experience in their chosen disciplines and that there was a strong multidisciplinary orientation in this sample. In addition, there was enormous diversity in the therapy approaches, modalities, and sexual-abuse-related treatment components that they reported to use with their clients with developmental disabilities. Emphasis on multidisciplinary training and the use of diverse approaches is consistent with recommendations from the literature that professionals draw from different sources of disciplinary knowledge, and underscores the importance of professionals' flexibility. There also are variable relationships between the types of specialized communication training that professionals report that they either have or do not have, their reported use of specific devices or techniques or accommodations, and the types of clients with varying types and levels of disabilities for whom these professionals provide therapy services.

There were some variations in the types of communication training that professionals had and the clients to whom they provided therapy services. For example, professionals who reported not having specialized communication training were less likely to provide therapy services to clients with either severe or profound intellectual or sensory disabilities. Alternately, professionals, who reported the largest percentages across all of the specialized communication training categories, were more likely to report providing services to clients with severe and profound intellectual disabilities and sensory disabilities.

There were also variable relationships between the kinds of devices or techniques and accommodations that respondents used and the clients they reported to serve. For example, devices that were used with relatively low frequency (i.e., speech/lip-reading, projective techniques, and special symbol systems) were consistent across all the categories of client disability. Devices that were used with higher frequency, such as sign language, electronic and non-electronic devices, and the use of a translator or interpreter who is familiar with the client's communication style, were used more frequently by respondents who served clients with severe and profound intellectual disabilities, sensory, communication, multiple, and motor disabilities. A substantially higher proportion of respondents reported using therapy accommodations, and devices or techniques that were used far less frequently. This finding appears to be consistent with a pattern of use that would be expected in view of the patterns of clients, in terms of their level and type of disabilities, who were reported to be receiving these therapy services. There was less variability, however, between the accommodations used and the clients that respondents served, than that noted for the use of devices or techniques and the clients respondents served.

Accommodations that were reported by over 80% of respondents across all categories of client disability included the use of concrete language, plain English, learning clients' non-verbal communication, and providing clients with additional time. The proportions for the less frequently reported accommodations (i.e., the use of less verbally oriented therapies and learning client's verbal communication) ranged between the mid-sixties to the high seventies across all categories of client disability. A substantially lower proportion of respondents, however, reported using less verbally oriented therapies and working with clients with moderate intellectual disability (58%).

Also, professionals in this sample reported a range of difficulties in providing this therapy, that included actually adapting therapy and overcoming various educational, collegial, financial, and systemic obstacles (e.g., obtaining varying levels and types of support, receiving collegial validation, specialized communication training, and supervision for conducting the therapy). Although some of these issues are not unique, some of these identified problems are distinct to providing treatment for people with developmental disabilities. Also some problems appear to be related to the devalued status attached both to people with developmental disabilities and the frequently segregated, disability-based services that are created for them. Greater study and advocacy efforts are needed to consider the sources of these distinct difficulties and to produce alternatives that ensure that people with developmental disabilities receive the treatment that they require from professionals who are adequately trained and supported in these endeavors.

Limitations

Although some preliminary patterns (between professionals' specialized communications training, use of specific devices or techniques, or accommodations, and the clients they report to serve in terms of their types and level of disability) have been described here, the results of this study need to be interpreted cautiously. These results are descriptions of patterns that neither suggest a cause and effect relationship between clients' types and level of disability, and professionals' use of specific techniques or accommodations nor do these suggest that these results are generalizable to other professionals engaged in this work. In some patterns, large proportions of respondents reported using particular accommodations and reported working with clients with specific disability characteristics, however, there are a numerous ways of interpreting these findings. For example, it could be that these accommodations are effective, commonly used, or necessary with clients with specific levels of disabilities or specific deficits such as sensory or communication impairments. It could also be that professionals working with some clients may require additional specialized training to provide appropriate therapy services, especially as this pertains to the use of specific devices and so forth. It must also be considered that respondents used multiple categories to describe their use of devices, techniques, or accommodations, and that this study did not use methods to determine professionals' rankings about frequency of use, or perceived efficacy as these pertain to clients with particular types or patterns of disabilities. Similarly, respondents could also use multiple categories to describe their typical client's disabilities; however, there is considerable heterogeneity both within and across categories of disability, and some definitions vary across continents (e.g., the term learning disability is equated with mental retardation in the UK and the term learning disability is equated with specific disabilities in particular areas, but not to overall cognitive functioning, as in North America). Therefore, these descriptions provide an initial sketch of the accommodations that professionals say they use and the general characteristics of the clients they typically serve. These do not necessarily provide specific, detailed information about what factors influence a therapist to use particular accommodations with clients who have variable patterns of disabilities and strengths. Further research will be necessary to examine this in greater detail.

Conclusion

Future research needs to expand on the initial descriptions about therapy accommodations. More information about what accommodations professionals consider to be the most effective for addressing some of the more common difficulties in therapy and helpful for working with clients with particular needs is necessary. Subsequent research should include examination of therapy process and communication patterns to help determine the knowledge and skills required for professionals to appropriately accommodate therapy, the specific therapist-client factors that influence their use in therapy, and therapy outcome research. This research may have implications for development of therapy outcome measures, professional training programs, and treatment protocols, and may promote greater cooperation between disability, mental health, and other disciplines. Professionals' consideration of the impact of their clients' disabilities underscores the importance of professionals obtaining specialized disability-related training, supervision, and consultation. Also encouraging new mental health professionals to expand their expertise into traditionally neglected areas such as developmental disability is critical for the continued development and refinement of these services. Promoting development and collaboration in all of these service areas and disciplines may ultimately help alleviate the current inadequacy of sexual abuse treatment services and encourage the provision of more integrated mental health services for people with developmental disabilities.

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CONCLUSION

In this dissertation three papers were presented. The first of these papers, provided a review of the literature covering the effects of sexual abuse in children with developmental disabilities with emphasis placed on the detection of sexual abuse and its implications for school personnel. The remaining two papers included the results from two separate studies. In the first study, the reported clinical findings found in children with and without developmental disabilities who have been referred for treatment of child sexual abuse, were compared. In the second study, the results of an international survey of professionals who provide therapy services to people with developmental disabilities who have been sexually abused were described. The emphasis in this study was placed on the accommodations that professionals used when providing therapy to clients with various disabilities and the problems they encountered. The implications drawn from the literature review and the two studies will be discussed here in terms of the limits of current knowledge and the directions for future research, treatment, and the training of professionals.

Implications of the limits of our knowledge for research and practice

The effects of child sexual abuse and the problems of detection

The findings from the literature review suggest that it has become increasingly important that school personnel develop both the awareness of and the skills to detect sexual abuse in children with developmental disabilities. For a number of reasons detecting child sexual abuse in this increasingly integrated group of students is a complicated issue.

It is important to acknowledge that there are limits to our knowledge of these issues at this time. This is particularly true of detecting child sexual abuse in children with developmental disabilities. Much of our knowledge is based on our understanding of sexual abuse in children who do not have disabilities, although this research literature provides an invaluable foundation for our understanding of child sexual abuse. The limited literature that is specific to people with developmental disabilities, however, focuses primarily on case studies and suggests that the effects appear to be similar but that there are some differences. At this time, it is not yet clear exactly how or if these effects differ from those noted in children who do not have disabilities (as is evidenced from the results in the first study in this dissertation). Although the results of this exploratory study suggest that the clinical findings in children with and without developmental disabilities are similar, there were differences. These results are consistent with this research literature, however, this area of study is in its early stages. It is not yet clear exactly how the presence of a developmental disability may influence the effects of child sexual abuse. The research pertaining to the effects in people with developmental disabilities, however, provides an important foundation. Nevertheless, there remains an enormous amount of clinical research that needs to be conducted to learn more about the influence of mental retardation on the presentation, diagnostic process, assessment, and treatment of mental disorders. The growing dual-diagnosis research literature holds significant promise for helping researchers and clinicians learn about the interactions that can occur between developmental disability and the variable psychological problems associated with child sexual abuse. Future research in this area will need to integrate research findings and clinical knowledge from the developmental disability, mental health, and dual-diagnosis-related disciplines.

Reporting problems

Reporting the sexual abuse of children with developmental disabilites may be further complicated by a myriad of factors. As outlined in the literature review, school personnel require clarity and guidance about their roles and responsibilities in reporting suspected child sexual abuse. School administrators and other personnel need to appreciate the potential influences of personal and systemic issues when engaging in this process and to understand how to implement protocols for responding to suspicions of abuse. School administrators need to be particularly cognizant of the difficulties that such situations may pose for the school personnel involved and to actively consider how to promote the self-care for school personnel (e.g., considering how staff may be dealing with personal reactions, being aware of the presence of conflicts and other dynamics with co-workers, being supportive to and encouraging the personnel involved to get counselling if required). School administrators and school personnel also need to have a clear understanding of the barriers there may be to reporting, how abuse protocols are to be used, school policies, and how to respond to situations involving accusations concerning either administrative or school personnel.

Prevention strategies and programs

Although prevention strategies are often thought of in terms of discrete actions that professionals can take to directly address child sexual abuse (e.g., the use of an educational program or referral to a special consultant), many important strategies can be used that do not require a special referral. For example, it is critical that school personnel be conscious of the potentially abusive implications that various educational practices, within their own schools, may have for students with developmental disabilities. Advocating for more respectful educational alternatives that promote students' self-respect, autonomy, and reduce their social isolation constitute important sexual abuse prevention strategies. Also advocating for increased access to inclusive social supports, community resources, and mainstream mental health services will benefit the sexually abused child with a developmental disability and his or her family. There are several sound interventions and advocacy-related activities that school personnel and other professionals can use to provide support and to help children and their families reduce the risk for additional abuse. It is important to acknowledge, however, that there are also limitations to our knowledge of these issues.

This is particularly true of the use of sexual abuse prevention programs for children with developmental disabilities. Many of the earlier, more traditional sexual abuse prevention programs have operated from outdated understandings of child sexual abuse (e.g., prevention models that present strategies for children that focus on the stranger as a potential source of danger in sexual abuse) and are increasingly being replaced with programs that have a more contemporary understanding of these issues (e.g., prevention models that present strategies for children based on the nature of touch and associated feelings). Also many professionals have applied programs developed for children without disabilities to children with developmental disabilities without regard for how the needs of these children will by necessity differ (e.g., in terms of cognitive, comprehension, and social considerations).

The implementation of educational programs that have been developed for children with developmental disabilities requires careful consideration of numerous issues. Many of these issues are related to considering the students' specific sources of vulnerability (e.g., lack of knowledge of sexuality, inadequate opportunity to practice social skills or have access to normative sexual/social relationships, poor social discrimination skills, socialization towards acquiescence and dependency, society's tendency to devalue people with developmental disabilities), psychological and social issues (e.g., social stigma, loneliness, and social isolation), and cognitive characteristics (e.g., difficulties with generalizing concepts they learn to other settings, and requiring considerable repetition, support, and practice to master skills, among other issues). It is notable, however, that there has been little, if any, study to determine the efficacy of these programs. Future research needs to be dedicated to determining if these prevention strategies and educational programs are helpful, and if so, under what circumstances. With the increasing recognition of the mental health needs and heightened risk for sexual abuse in people with developmental disabilities, however, more professionals working in this area need to be aware of the effects of sexual abuse in this vulnerable group for the development of treatment strategies. Clinicians need to consider the multiplicative impacts of developmental disability and associated mental health issues, vulnerability to abuse, and diagnostic issues on the presentations of sexual abuse related trauma in order to identify treatment issues and provide appropriate, responsive treatment.

Treatment

The concluding study in this dissertation involved a review of this literature and a survey for professionals who provide these services to people with developmental disabilities who have been sexually abused. The literature primarily suggested the importance of therapists actively, and flexibly adapting their therapy practices in order to ensure that it is appropriate and that its effectiveness is enhanced for this population.

The results of the survey provided information about who provides treatment, the types of problems professionals encounter, the specific components of treatment that professionals use, the clients who are typically served by these professionals, and the accommodations that are used when providing therapy. In this sample, professionals providing these services often reported having multidisciplinary experience and using diverse therapy approaches. Emphasis on multidisciplinary training and the use of diverse approaches is consistent with literature recommendations that encourage professionals to draw from different disciplines as helpful resources in treatment, and underscores the importance of professionals' flexibility. There also are variable relationships between the types of specialized communication training that professionals reported that they either have or do not have, their reported use of specific devices or accommodations, and the types of clients to whom these professionals provide therapy services. For example, professionals who reported not having specialized communication training were less likely to provide therapy services to clients with either severe or profound intellectual or sensory disabilities. Alternately, professionals who reported the largest percentages across all of the specialized communication training categories, were more likely to report providing services to clients with severe and profound intellectual disabilities and sensory disabilities. The results of the survey suggest that, at least to some degree, the nature and type of client's disabilities influence the type of accommodations that professionals use and that having specialized communication training may be a therapeutic necessity when working with clients who have certain types of disabilities.

Accommodations that were reported by over 80% of respondents across all categories of client disability included the use of concrete language, plain English, learning clients non-verbal communication, and providing clients with additional time. Less frequently reported accommodations included the use of less verbally oriented therapies and learning client's verbal communication. Even fewer respondents, however, reported using less verbally oriented therapies.

Also, professionals in this sample reported difficulties in providing therapy, that included actually adapting therapy and overcoming various educational, collegial, financial, and systemic obstacles (e.g., obtaining varying levels and types of support, receiving collegial validation, specialized communication training, and supervision for conducting the therapy). Although some of these issues are not unique, some of these identified problems are distinct to providing treatment for people with developmental disabilities and appear to be related to the devalued status attached to people with developmental disabilities and the segregated, disability-based services that they receive.

Future research needs to expand on these preliminary descriptions of therapy accommodations and obtain data about what accommodations professionals consider to be the most effective for addressing some of the more common difficulties in therapy and helpful for working with clients with various patterns of disabilities. Subsequent research should include examination of therapy process and communication patterns to help determine the knowledge and skills required for professionals to accommodate therapy, the therapist-client factors that influence their use in therapy, and therapy outcome research. This research may have implications for development or expansion of professional training programs, treatment protocols, and may promote greater cooperation between disability, mental health, and other disciplines. Encouraging new mental health professionals to expand their expertise into traditionally neglected areas such as developmental disability is critical for the development of these services.

More research and advocacy efforts are needed to examine the sources of the difficulties associated with treatment provision. Alternatives need to be developed that ensure that people with developmental disabilities receive the treatment that they require from professionals who are adequately trained and supported in these endeavors. Future research on sexual abuse effects, prevention or risk reduction strategies, and treatment accommodations and their efficacy may help alleviate the current inadequacy of sexual abuse treatment services and encourage the provision of more integrated mental health services for people with developmental disabilities.

There are numerous avenues for future researchers to examine. This research can use a wide range of methods and strategies to address the various, sometimes complex issues, concerning the sexual abuse of people with developmental disabilities. Developing and refining a greater knowledge base of dual diagnosis and trauma related issues and the efficacy of treatment approaches and accommodations has considerable implications for future multidisciplinary professional training and service provision.

Appendix A
The Sexual Abuse Information Record (SAIR)
File Information

FILE INFORMATION #_______

Referral source: ___ self ___ police ___ MSSH ___ agency ___ other (______)

Region of residence at time of referral __________ at time of abuse

VICTIM INFORMATION

Gender: M ____ F ____

# of offenders ________

Age when: abuse began ____ abuse terminated ____ in counselling _____

Reason abuse terminated ____

Disclosure situation ____

Ethnic background ____

Mental disability ____

Physical disability ____

FAMILY DEMOGRAPHICS

# of siblings ____ Brother(s) ____ Sister(s) _____ Birth order of victim ___

Other replacement siblings _____ males ____ females (explain) ______

Biological parents' marital status at time of abuse:

separated ___ divorced ___ common-law ____ married ____ single ___

Mother's marital status during counselling in relation to child's biological father:

same mate ____ different mate ____ separated ___ divorced ___ married ___

common-law____ single ____

FAMILY ABUSE HISTORY as related to primary victim (Use code below):
mother (**M**), stepmother (**SM**), grandmother (**GM**), mother substitute (**MS**)
father (**F**), stepfather (**SF**), grandfather (**GF**), father substitute (**FS**)
brother (**B**), brother substitiute (**BS**), sister (**S**), sister substitute (**SS**)
uncle (**U**), aunt (**A**), male cousin (**MC**), female cousin (**FC**), brother/sister-in-law
(**BL/SL**) If a substitute, please explain ______________________________

Offender Relationship to Victim **Type of Abuse**

	sexual	**physical**	**emotional**	**neglect**	**alcohol**	**drugs**

OFFENDER AND ABUSE INCIDENTS INFORMATION (File #___)

Offender #____ Possible # of offenders ____ Additional pages attached _____ .
Gender: M ___ F___
Age of offender at time offence began ____ offence ended ____ duration ____
Difference in age of offender and victim ______
Frequency of offence ___ once ___ 2-10X ___ more than 10X
Education/occupation during abuse ____
Marital status: separated ___ divorced ___ common-law ___ married ___
single ___
Offender addictions: drugs___ alcohol ____ other (specify) _________
Other abuse by offender: ____ physical ___ emotional (verbal) ___ neglect

Relationship to victim:
stranger___ casual acquaintance/neighbor ___ boyfriend/girlfriend ___
position of trust (babysitter, teacher...) ___ father/mother ____
stepfather/stepmother parent's mate parent substitute
brother/sister/stepbrother/stepsister/sibling substitute ___uncle/aunt/cousin ___
grandfather/grandmother ___
other (specify)____

Classification of abuse:
__ Intrafamilial __ Extrafamilial ___ Both (indicate which was first if known)

Type of sexual abuse:
____ **Very intrusive sexual abuse** (completed and attempted vaginal, oral, anal intercourse, cunnilingus, analingus, forced and unforced*)

____ **Intrusive sexual abuse** (completed and attempted genital fondling, simulated intercourse, digital penetration, forced and unforced)

____ **Less intrusive sexual abuse** (completed and attempted acts of intentional sexual touching of clothed breasts or genitals, forced and unforced)

____ **Nonintrusive sexual abuse** (no physical contact-exhibitionism, obscene call)*
The term force includes physical force, threat of physical force, or inability to consent because of being unconscious, drugged, asleep, or in some other way totally physically helpless.

Abuse Patterns: **no ___ yes ___ (please specify below):**
Time (e.g. after school, holiday visits...) ______________________________
Place (e.g., bedroom, bathtub, daycare...) ______________________________
Other pattern(s) ____

Appendix B

The Sexual Abuse Information Record (SAIR)

Sexual Abuse Sequelae During Counselling

Sexual Abuse Sequelae During Counselling

FILE # __________ F=frequently, O=occasionally, R=rarely, ___ = not mentioned

A. SCHOOL/ACADEMIC/WORK ACTIVITIES

__ a) Insists on going to school/daycare/work even if ill
__ b) Avoids school/daycare/work
__ c) Shows sudden decline in grades or school/work performance
__ d) Has difficulty concentrating or staying on task
__ e) Refuses to participate in some school/work related activities
__ f) Extremely demanding/withdrawn at school/work
__ g) Unwillingness to undress for gym or participate in physical education/activities
__ h) Sexualized or bizarre art work or stories which depict themes of sexually abusive behavior (e.g., body proportions skewed, death wishes...)

B. PERSONAL RELATIONSHIPS

__ a) Is too easily led or influenced
__ b) Tries too hard to please others
__ c) Is very shy or withdrawn - avoids peers/men/women
__ d) Has few friends
__ e) Inability to establish trusting/close personal relationships
__ f) Displays dominant/aggressive behavior toward others
__ g) Shows inappropriate anger
__ h) Repeats a pattern of engaging in abusive relationships

C. SEXUALITY

__ a) Initiates "sexual games" with adults/children
__ b) Touches self/adults/children excessively or inappropriately
__ c) Masturbates excessively for age level
__ d) Confusion regarding his/her sexual orientation
__ e) Experiences sexual dysfunction - impotency, fear of sexual initimacy, dislikes sex
__ f) Verbalizes inappropriate "sexual" remarks or comments
__ g) Preoccupied with sexual thoughts/fantasies (e.g., pornography, doll's genitals during play...)
__ h) Approaches strangers inappropriately - poor sense of personal safety
__ i) Is approval seeking with adults/children
__ j) Presents as a "little" adult
__ k) Dresses inappropriately (e.g., seductively/layering)
__ l) Has difficulty distinguishing between affection and sexual encounters
__ m) Is sexually active or has knowledge of sexual activity inappropriate to age level
__ n) Has little/no age appropriate sexual knowledge

D. BEDTIME

__ a) Avoids going to bed or refuses to sleep alone
__ b) Insists on sleeping fully clothed
__ c) Sleep disorder (insomnia, hypersomnia, uses medication...)
__ d) Refuses to sleep in bed, preferring chair, floor,...
__ e) Keeps a weapon such as a club or knife close by bed
__ f) Has nightmares/recurring dreams

E. HYGIENE

__ a) Exhibits excessive modesty surrounding bathrooms functions
__ b) Is immodest, uninhibited in the bathroom/other areas
__ c) Tries to "spy" on or intrudes on others in areas of privacy
__ d) Becomes agitated during bathroom/bedroom routine
__ e) Appears unkempt/dirty or cleans/grooms self excessively
__ f) Excessive problems with menses (e.g., obsessive fear or fascination, poor hygiene...)

F. BEHAVIORAL/EMOTIONAL

__ a) Appears depressed/threatens or attempts suicide
__ b) Homicidal ideation
__ c) Shows a sudden behaviour change ____________________
__ d) Runs away or threatens to run away
__ e) Seems unusually nervous or anxious
__ f) Shows phobic or other avoidance behaviour (e.g., panic attacks, flashbacks...)
__ g) Displays extreme fear of a certain place/person/situation (e.g., unwillingness to see someone/go somewhere)
__ h) Has memories/fears/bouts of choking, suffocating, stuttering
__ i) Expresses fear about losing control and becoming abusive to others
__ j) Shows regressive behavior (e.g., thumbsucking, enuersis, encopresis, baby talk, clingy behavior.. .)
__ k) Makes unusual comments about family or home life
__ l) Is overly interested in genital areas of dolls during play
__ m)Displays attention seeking/needy behaviors (e.g., lying, exaggerating, stealing, interrupting, malingering...)
__ n) Has a change in appetite and/or anorexic/bulemic tendencies
__ o) Has poor self-esteem (e.g., unassertive, guilt, shame, poor body image...)
__ p) Assumes "victim role" (e.g., procrastination, overly dependent on others...)
__ q) Use/abuse of substances (alcohol, drugs, cigarettes...)
__ r) Experiences dissociative episodes: withdrawl into fantasy __, inability to focus/concentrate __, intense ego state changes __, intense ego state changes with some memory loss __, MPD __, repressed memories from childhood ___
__s) Detachment of cognitive functioning from emotional functioning (e.g., inability to discuss feelings, lack of appropriate affect in emotional circumstances...)
__t) Self abuse (e.g., hair pulling, head banging...) _____

G. MEDICAL

__ a) Complains of pain during urination
__ b) Has vaginal/penile discharge, inflammation, swelling, or bladder infections
__ c) Has bruises, scratches, bites, or "passion" marks
__ d) Has injury to lips or genital area (blood stains on underwear, rash around lips...)
__ e) Has pain in anal, genital, gastrointestinal or urinary area
__ f) Complains of headaches/stomach aches
__ g) Acts inappropriately during a medical exam
__ h) Pregnancy inappropriate for age or partner
__ i) Develops a sexually transmitted disease
__ j) Appears accident/illness prone

Appendix C
Victoria Child Sexual Abuse Society
Application for Service

Victoria Child Sexual Abuse Society
Application For Service

Please check off the services that you are requesting or you would like more information about:

1) ___ Child and/or family assessment and counselling
2) ___ Information and support throughout your involvement with the criminal justice system
3) ___ Safety skills training for child
4) Education and supprt groups:
    ___ Mom's group
    ___ Parent's group
    ___ Children's group
    ___ Teen's group

I am requesting the above services provided by the Victoria Child Sexual Abuse Society (VCSAS) in dealing with difficulties experienced by myself, child and/or family related to child sexual abuse.

I understand my involvement with the VCSAS is voluntary and confidential. Counsellors will be assigned as available and necessay to provide the services I have requested. I understand that confidential services means that the release of any information regarding my involvement with VCSAS may only occur with my written and signed consent. I have been informed that the exceptions to the confidential policy are:

> a) unreported cases of suspected child abuse or neglect. VCSAS staff are obligated to inform appropriate persons in the Ministry of Social Services and Housing.
>
> b) when a client indicates that he/she is in danger to himself/herself or others, VCSAS staff are obligated to inform the proper authorities.
>
> c) upon subpoena to testify in court at the direction of a judge.

I also understand that information from my file may be used anonymously by VCSAS for the purposes of research into the prevention and intervention of child sexual abuse.

Re: Missed Appointments

If an appointment is missed without at least 24 hours notice, you may be charged $20.00

____
Signature

____
Date

Appendix D
Cover Letter for Therapy Accommodations Study

January, 1995

Dear Participant,

I am writing to ask you to consider distributing research report forms through your agency. The Abuse and Disability Project, Developmental Disabilities Centre, at the University of Alberta is funded by the Social Sciences and Humanities Research Council of Canada to study sexual abuse of children with disabilities and sexual assault of adults disabilities. Research conducted through this project includes studies on sexual abuse patterns, prevention strategies, and treatment for people with developmental disabilities. As part of this ongoing research effort a new study is being conducted on the adaptations or accommodations that therapists use in providing therapy to people with developmental disabilities who have been sexually abused.

This research includes a survey of various professionals who provide therapy services to people with developmental disabilities who have been sexually abused. The survey's questions are directed toward the therapeutic practices and accommodations professionals use with particular clients, and the difficulties they encounter in providing therapy services. People with developmental disabilities encompass an extremely heterogeneous group and therapists need to individualize therapy by recognising and working with the unique qualities of the person with a developmental disability so that it is appropriately adapted to fit the client's special needs. Accommodations or adaptations refer to any changes, in terms of providing therapy that a therapist may make, to ensure therapy appropriateness for the client's developmental level, communication, comprehension, and language abilities. For example, adaptations that a therapist may use when working with a client with a developmental disability could include modifications in their use of language i.e. making their language simpler, more concrete, and less abstract to ensure greater client comprehension. Additional accommodations could include the use of less verbally oriented therapies or various alternative or augmentative communication devices that ensure that clients with limited expressive language or those who are described as nonverbal may participate in therapy. These are only a few examples that are possible that have been provided to give potential participants in this study an idea of the specific material we are attempting to address in this research project.

Participation in this study is completely voluntary. Agencies or individuals may choose not to participate for any reason whatsoever. Responses will be kept confidential and responses will be anonymous to the researchers to protect their identities. Also participants are requested to preserve and protect their clients' confidentiality by avoiding the use of names or any other identifying information.

More information about the survey is included in the attached information letter to respondents. Potential respondents should be given the information on the attached page along with the survey form. Whether or not your agency chooses to participate, you may wish to learn more about this project. If you have any questions about this survey or any aspect of this project please contact Sheila Mansell or Dick Sobsey, Abuse and Disability Project, Developmental Disabilities Centre, University of Alberta, 6-102 Education North, Edmonton, AB, T6G 2G5, Canada (403) 492-1142 or (403) 492-3755, Fax (403) 492-1318. E-mail address Dick.Sobsey@ualberta.ca or Sheila.Mansell@ualberta.ca

Thank you for considering this request.

Sincerely

Sheila Mansell

Abuse and Disability Project
Study of Therapist Accommodations

Dear Participant:

I am writing to ask your help on a research project designed to learn more about the therapy practices, and adaptation or accommodation strategies that therapists use when providing therapy to people with developmental disabilities who have been sexually abused and the problems or difficulties they encounter in providing therapy.

As a participant in this study you should have received a cover letter and information sheet describing the study, a two-part questionnaire, and a self-addressed stamped envelope. The first part of the two-part questionnaire requests information about your professional training and discipline, theoretical orientation, experience in providing sexual abuse therapy and working with clients with developmental disabilities, and a description of the clientele with whom you most typically conduct therapy. You will also be asked to indicate the type of therapy you provide to the clients that you identified as most typical of the clients with whom you work i.e. respond on basis of individuals with disabilities with whom you have the greatest experience. The second portion of the survey includes questions about the therapeutic approaches and types of accommodations used with clients with particular disabilities. Participants will also be asked to describe specific difficulties they encounter in providing therapy.

Please take 30 minutes sometime in the next two weeks to fill out the enclosed survey and return it to me. Your participation will be voluntary and you have the right to refuse participation for any reason. Your responses will be completely confidential and we will not determine or keep data on who provided any specific answers. Participants are specifically asked to preserve the confidentiality of those persons they serve, using no names or other identifying information that might harm their clients. Completion of the questionnaires indicates participants' consent to participate and follow the guidelines set forth in the study.

We appreciate that time is valuable and we cannot compensate you for your time. Nevertheless we believe that this project is important and your contribution to the study will be valuable. Studying the accommodations therapists use and the problems they encounter has several potential benefits as it may provide more detailed information about specific techniques, practices, and adaptations that professionals use for particular clientele, and a description of problems encountered. Learning more about these specific practices may contribute to the development of training programs, treatment protocols, and therapy programs. Development in these areas may help alleviate the inadequacy of sexual abuse treatment services and encourage more integrated services for people with developmental disabilities. If you would like a report of our findings, we will be glad to share it with you.

For the purpose of this study, the term developmental disabilities refers to group of neurological deficits that cause impaired functioning in areas such as intelligence, motor abilities, and personal-social interaction, are exhibited before 22 years of age and are frequently attributable to mental retardation, autism, cerebral palsy, epilepsy and other conditions. Accommodations or adaptations refer to any changes, in terms of providing therapy that a therapist may make, to ensure therapy appropriateness for the client's developmental level, communication, comprehension, and language abilities. For example, adaptations that a therapist may use when working with a client with a developmental disability could include modifications in their use of language i.e. making their language simpler, more concrete, and less abstract to ensure greater client comprehension. Additional accommodations could include the use of less verbally oriented therapies or various alternative or augmentative communication devices that ensure that clients with limited expressive language or those who are described as nonverbal may participate in therapy. These are only a few examples that are possible that have been provided to give participants in this study an idea of the specific material we are attempting to access in this research project.

We look forward to receiving your response and thank you for considering this request.

Sincerely,

Sheila Mansell

Appendix E
Therapy Accommodations Survey Form

Therapists' Accommodations Survey

Part 1 Instructions

Please complete all of the following sections and return this survey to **Sheila Mansell or Dick Sobsey, Abuse and Disability Project, University of Alberta, 6-102 Ed. North, Edmonton, Alberta, T6G 2G5, Canada**

1. Please indicate your **professional title** and indicate your **highest level of education** attained. **(please do not provide your name).**

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2. Specify the **number of years and/or months** that you have been providing therapy to people with developmental disabilities.

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3. Please identify your area(s) of **specialization/training** by marking the appropriate discipline(s) listed below.

○ Psychiatry ○ Psychology ○ Nursing ○ Social Work
○ Rehabilitation ○ Special Education ○ Other ____________

4. Please indicate the **country** in which you practice.

○ Canada ○ U.S.A. ○ New Zealand ○ United Kingdom ○ Other

5. Indicate **any special communication training** you have received.

○ electronic communication devices (e.g., computers)
○ nonelectronic communication devices (e.g., communication boards)
○ alternative language forms (e.g., PIC, Bliss, etc.).
○ sign language (e.g., ASL, BSL, CSL, etc.).
○ other (please specify)
____
____

○ not applicable

6. Identify **therapeutic approach(es)** that most closely represent your work? Also you may specify any **particular modalities (e.g., individual, group, family, etc.)** that you use on the lines provided.

○ Psychodynamic ____________________________
○ Behavioral or ○ Cognitive-Behavioral ____________________________
○ Eclectic ____________________________
○ Object Relations ____________________________
○ Feminist ____________________________
○ Family Systems ____________________________
○ Psychoeducational ____________________________
○ Other (please specify) ____________________________
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7. Indicate the **clients with whom you have the most experience** by identifying the **characteristics** that best describe your clients.

Age Group

○ (0-5 yrs) ○ (5-10 yrs) ○ (10-15 yrs) ○ (15-20 yrs)
○ (20-30 yrs) ○ (30-50 yrs) ○ (50-60 yrs) ○ (60 yrs +)

Gender

○ M ○ F ○ Both Male and Female Clients

Level of Intellectual Disability

○ Mild ○ Moderate ○ Severe ○ Profound

Type(s) of Disability (please specify)

Mental/Intellectual ____________________
Motor ____________________
Sensory ____________________
Communication ____________________
Psychiatric/Psychological ____________________
Multiple Disabilities ____________________

Part 2

Therapy Practices and Accommodations

1. Indicate by marking in the boxes provided any **special problematic areas or issues** that present difficulties **particular to the provision of therapy services to your clients with developmental disabilities**. Special problems or issues, as used here, refers to the problems you have encountered in the actual practice of therapy.

○ adapting therapist communication style to meet client's communication and comprehension needs in therapy
○ adapting therapist communication style to meet client's communication and comprehension needs for assessment purposes
○ matching therapy techniques flexibly and creatively
○ inadequate professional and financial support for therapy programs
○ inadequate psychoeducational or resource materials for use in therapy
○ inadequate access to communication alternatives for use in therapy
○ eliciting cooperation from staff or family members for therapy
○ other problems (please specify) ____________________

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2. Instructions

In the following section please be specific as possible. The choices presented include modifications that respect client's various difficulties in sensory modalities, comprehension, and language reception or production. More than one response may be appropriate. **Indicate which if any, of the following therapy accommodations you have used** in providing therapy to a person with a developmental disability.

For any of your selected items please **specify** on the line provided **the nature of the client's disability that has dictated your use of a particular therapy accommodation**. For example indicate if you use a particular accommodation because a client is **described as nonverbal, or has difficulties with comprehension, or receptive and/or expressive language disabilities, etc.**

Accommodations

○ use of concrete language.

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○ use of plain english (e.g.,use of shorter sentences with simple words)

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○ use of less verbally oriented therapies (e.g., play, art, sand, dolls, etc.)

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○ use of projective techniques.

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○ electronic assistive communication devices (e.g., computers).

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○ nonelectronic assistive communication devices (e.g., communication boards).

____

○ providing additional time for the client to respond.

____

○ learning the client's communication style (e.g., clients' use of non verbal (body) language, idiosyncracies, and gestures)

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○ learning the client's communication style (e.g., clients' use of intonation, articulation, speech patterns, idiosyncracies)

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○ speech/lip-reading.

____

○ sign language (e.g., ASL, BSL, CSL, etc.).

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○ use of a translator or interpreter who is familiar with client's communication style.

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○ use of special alternate languages (e.g., Bliss, PIC, etc.).

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○ other therapy accommodations

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3. In the following section please be specific as possible. The choices presented include modifications in therapy techniques or components in the treatment of sexual abuse. More than one response may be appropriate. **Indicate which, if any, of the following therapy techniques or components you have used in providing therapy to a person with a developmental disability who has been sexually abused.**

Therapy Techniques and/or Components

○ use of psychoeducational techniques to teach clients concepts

○ therapist use of repetition to teach concepts in therapy

○ use of *in vivo* training to promote concept generalization outside therapy

○ use of psychoeducational techniques to teach clients an affective vocabulary

○ use of social skills/sexuality education as a component in therapy

○ use of sexual abuse or risk reduction education in therapy

○ use of assertiveness training in therapy

○ use of behavioral approaches in therapy to address secondary behavior problems (e.g., sexualized behavior, aggressiveness, etc.)

○ use of more directive approaches to maintain focus and structure in therapy

○ enlisting parents/guardians or staff members for support where appropriate

○ other(s) therapy techniques or components

4. Hearing impairment, deafness, or hard of hearing

In the final section please be specific as possible. The choices include modifications that respect client's various difficulties in sensory modalities, comprehension, and language reception or production. More than one response may be appropriate. **Indicate which, if any,** of the following **therapy accommodations you have used** in providing therapy to a person with a developmental disability who also has a **hearing impairment or is described as deaf or hard of hearing.**

For any of your selected items please **specify** on the line provided **the nature of the client's disability that has influenced your use of a particular therapy accommodation.** For example indicate if you use a particular accommodation because a client has a **hearing impairment or is described as deaf or hard of hearing etc.**

Accommodations

○ use of interpreter/translator in session.

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○ therapist uses sign language (e.g., ASL, BSL, CSL, etc.).

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○ therapist uses family member as interpreter in session.

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○ use of FM systems, hearing aids, assistive listening devices.

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○ use of less verbally oriented therapies (e.g., play, art, sand, dolls, etc.)

____

○ learning the client's communication style (e.g., use of nonverbal (body) language, intonation, articulation, speech patterns, and gestures).

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○ speech/lip-reading.

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○ finger spelling.

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○ use of a translator or interpreter who is familiar with client's communication style.

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○ other(s) therapy techniques or accommodations, please specify.

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